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OVERVIEW OF THE MEDICAID PROGRAM

Medicaid is a medical assistance program designed to provide access to mainstream health care to certain low-income persons who are blind, disabled, aged, or members of families with dependent children. The program operates on the basis of a State and Federal division of responsibilities. The Federal government establishes regulations, guidelines, and policy interpretations which describe the broad outline within which States can tailor their individual programs. States assume control and direction of operations. Funding is shared between the two bodies, with the Federal government matching State provider reimbursements at an authorized rate between 50% and 83%, depending on the State's per capita income.

Title XIX of the 1965 Social Security Amendments provided the legislative basis for Medicaid. It requires that participating States cover all persons receiving cash assistance under Aid to Families with Dependent Children (AFDC), as well as aged, blind, and disabled persons who (1) are receiving SSI cash benefits, or (2) can meet State Medicaid eligibility conditions more restrictive than those required under the SSI program. Medicaid allows a participating State the option of including medically needy persons. The medically needy are persons whose income and resources are too high to qualify as categorically needy, but who cannot afford to pay their medical bills. Their resources must be within State limits, and the amount of their incurred medical expenses must equal or exceed the amount of income they have above the State income level. At present, 32 States exercise this option. States may also include for Medicaid benefits certain aged, blind, and disabled persons eligible for State payments which supplement Federal Supplemental Security Income (SSI) payments.

The Medicaid legislation requires States with programs to provide the following services to Medicaid recipients: inpatient and outpatient hospital services, other laboratory and X-ray services, skilled nursing and home health services for persons 21 and over, physicians' services, family planning, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for individuals under 21. For the medically needy, States may either provide these same basic services or any seven of the services listed in the Act. States may also pay for other specified health care services, such as dental care and prescription drugs, and receive Federal matching funds for these optional services. These health care services are administered by providers who are reimbursed by vendor payments made directly from the States to the providers.

OVERVIEW

When the Medicaid program commenced operations in January of 1966, it reached about 5 million people, mostly affiliated with social welfare programs previously operative under the Kerr-Mills Act. In FY 1976, the program served over 23 million people. During its 10-year history, Medicaid costs have increased from $.4 billion to $15 billion (in non-adjusted dollars). Besides the more than doubling of the recipient population, this figure represents the 61% inflation in the cost of health care since 1970. The average Medicaid payment per recipient in 1970 was $311. In constant dollars the cost today is $402 (FY 1976), but over $616 in 1976 dollars.

Of the 23 million Medicaid recipients in FY 1976, 47.8% are children, requiring 17.4% of the budget. Adults in Families with Dependent Children comprise 22.4%, and this group receives 17.7% of the Medicaid dollar. The aged account for 19.2% of the recipient population, and benefit from 39.5% of the budget. Blind and disabled persons comprise 10.6% of the served group, and have expenses amounting to 25.4% of the total Medicaid costs. The relative sizes of these recipient groups and the amount of services they receive has remained constant throughout the history of the program.

The idea of making mainstream health care available to the medically indigent did not start with the passage of Title XIX of the Social Security Act, as amended in 1965. The "Great Society's" "War on Poverty" was the most ambitious effort of its type, but its roots lay in the social welfare work of previous administrations. Motivated by the depression, Congress passed the Social Security Act in 1935. This act established categorical assistance programs for needy, blind, and aged persons, and later for the disabled and for one-parent families with children. The Social Security Amendments of 1950 expanded the categories of public assistance and provided for a Federally supported program of direct vendor-reimbursement payments to physicians and hospitals. States were encouraged to participate in this program on a cost-matching basis. The Kerr-Mills Act of 1960 provided more generous, open-ended Federal matching for all vendor payments and established a new category of public assistance: "medically needy" aged persons who were not receiving cash assistance. By the end of 1965 (pre-Medicaid), 50 States and 4 jurisdictions had Federally approved programs for medical care.

The Medicaid program created by the 1965 legislation incorporated many structural features of the less ambitious Kerr-Mills system. The important ideas carried over from the earlier program were the Federal-State partnership, categorical delineation of recipient groups, and vendor payments for the reimbursement of health care providers.

Medicaid did not have the advantage of Medicare, its sister program, in being innovatively designed to meet clear-cut goals. Rather, it

was saddled with management problems arising from the inadequacy of the Kerr-Mills operational structure to handle the massive recipient population of Medicaid. Further problems were generated by the failure of its architects to delineate clear goals and practicable eligibility requirements. Consequently, Medicaid management has suffered from some severe and persistent problems:

- o A chronic shortage of staff and expertise at the State, Federal, and Regional levels.
- o Complex and frequently changing regulations, guidelines, and policy interpretations concerning eligibility, implementation procedures, and administration.
- o Lack of accountability for services rendered, and failure to accumulate useful data about utilization.
- o Lack of measurement of program effectiveness and performance.
- o Lack of management technology for auditing and claims processing needed to control the program effectively.

These problems have been addressed, with only a modicum of success, by both the Congress and the Executive Branch.

The Congress first attempted to improve the management of Medicaid in the 1967 Social Security Amendments. Federal guidelines were established requiring States to review, on a continuing basis, the cost, administration, and quality of medical care provided in their programs. Stricter standards for quality of care and utilization review were mandated for nursing homes. A preventive and comprehensive health program for children under 21, EPSDT, was also created. Thus, the Federal role in Medicaid was greatly expanded.

However, the expanded Federal role described by the 1967 Amendments proved impractical to fulfill. Basic management problems had not been addressed by Congress, and the States had not been allocated staff commensurate to their new demands. Without the necessary staff or expertise, States floundered and failed to respond adequately to their new directives.

In 1970, a Senate Finance Committee report and an independent DHEW task force (McNerney Report) underscored the need for better management of the Medicaid program. In a Congressional response to these suggestions, eighty new positions were assigned to the Federal level. Both improving management information systems in the States and strengthening procedures for developing policy guidelines and regulations were stressed.

These initiatives, however, had a marginal impact at the State operations level. Understaffing, internal contradictions, lack of management expertise and technology, and structurally cumbersome organization inhibited effective program implementation.

The Social Security Amendments of 1972 reflected the continued disenchantment of Congress with the program. In an effort to improve State compliance, penalty provisions were enacted which allowed Federal funds to be withheld from States for failure to implement the utilization review and EPSDT programs mandated by Congress. In addition, the Amendments established Professional Standards Review Organizations (PSRO's), to assure that care provided to recipients meets professional standards for quality, and that services are utilized appropriately.

Congressional attempts to resolve management problems failed to adequately address the basic difficulties of implementing complicated legislation, especially that concerning eligibility. The Amendments also failed to eliminate the confusion over whether accountability and program control should rest at the Federal or State level. From an initial posture of monitoring and advising, the Federal role has grown to include the function of oversight. Yet despite the increased expectation for Federal oversight of the 53 programs, the Federal capability has remained small. Thus, the Amendments added increased responsibility without adding commensurate resources and control.

Executive initiatives to improve Medicaid management have paralleled the Congressional attempts, with equally limited results. MSA management improvement concerns have focused on claims processing and information retrieval, financial management, eligibility quality control, utilization control, and fraud and abuse control.

In 1972, the Social and Rehabilitation Service (SRS) initiated an effort to improve the financial management of its public assistance programs. This technical assistance effort was designed to facilitate the monitoring of the States' financial management of their programs to ensure that reimbursement claims are made in accordance with the law.

Since 1970, SRS has been attempting to encourage State progress in improving the collection and use of management data. This was done by developing a general system design called the Medicaid Management Information System (MMIS) and beginning technical assistance efforts towards its implementation. This initiative was supported by 1974 legislation that permitted 90% Federal reimbursement for development and 75% Federal reimbursement for operation of the system. The MMIS, now operative or being developed in 35 States, incorporates surveillance and utilization review, and management reporting functions. This enables the continual provision of data on the cost and utilization of services.

A Medicaid eligibility quality control program, modeled upon the corresponding program of AFDC, was begun in 1975. Major initiatives were also begun to direct attention to problems in utilization control and provider fraud and abuse.

While these Executive efforts were important preliminary steps towards program improvement, they have not resolved basic operational problems. MSA believes that basic structural changes are needed in the way the program is managed if significant improvements are to be realized.

The Medical Services Administration (MSA) has developed a new management improvement initiative, which includes:

- Increasing to 90% the Federal administrative match to the States as an incentive to increase the size and expertise of their staffs.

- Helping States gain expertise in program management by increasing technical assistance efforts through an Institute for Medicaid Management.

- Developing performance standards for effective program management and for the utilization control and quality control assessment needed to assure performance standards are met.

- Increasing the accuracy and usefulness of management data at the State operations level by promoting MMIS and other data improvements to allow greater program auditing and control.

The combination of Congressional and Executive attempts to resolve the major management problems within the Medicaid system have had an impact on the scope of Medicaid programs and the efficiency with which services are delivered. However, during the course of Medicaid's development, certain problems have emerged as almost irresolvable. These are the problems associated with the bifurcated nature of the program, the Federal-State partnership, and problems related to the lack of integration between Medicaid and other programs such as Medicare, AFDC, and SSI. Strategies for dealing with management problems are discussed in detail in the chapters of this Forward Plan.

While management problems have been a continuing concern, of equal concern has been the growing cost of the Medicaid program. Since 1970, the Medicaid program has grown at a rate which surpassed the expectations of the legislators who created it. In FY 1970, the Medicaid program expended $4.5 billion to deliver services to 14.5 million people.

By FY 1976, the combined Federal-State cost of Medicaid had grown to $15 billion, and the served population had grown to over 23 million. This represents a 58% growth of the recipient population and a 233% increase in costs. During this time, the payments per Medicaid recipient grew from $311 (in constant 1970 dollars) to $402. In non-adjusted spending, this corresponds to a growth from $311 in 1970 to $616 in 1976.

Increases in the cost of Medicaid can be attributed to four factors:

- A 52% inflation in the cost of living, coupled with a 61% inflation in the cost of medical care between January 1970 and August 1976.

- Increases in the number of people served (60% since 1970), and increases in the number of States and jurisdictions offering Medicaid programs (from 40 in 1968 to 53 in 1976).

- Increases in services provided, notably EPSDT, intermediate care, family planning, and options such as medically needy programs (32 States) and supplementary programs.

- Increased utilization of available services.

Inflation, and inflation in the cost of health care, is a great contributer to the increased cost of Medicaid. Since 1970, inflation in the cost of health care has been 9% greater than in other sectors of the economy. There is a great concern that large-scale Federal health spending has contributed to this disproportionate increase, though conclusive data on this subject does not exist. However, it is evident that Medicaid, Medicare, and other public health programs have assumed an important role in the funding of many segments of the health care industry. For example, Medicaid underwrote 48.7% of all nursing home services in 1974. In the same year, public funds accounted for 31% of all expenditures for health care. Only recently has Medicaid been developing cost-control techniques to prevent Federal stimulation of a spiraling inflation in the cost of health care.

The "Prudent Buyer" strategy for the purchase of institutional care is one such cost-control mechanism being developed by MSA. Under this plan, which is discussed in the chapter on reimbursement, Medicaid would purchase institutional care on a competitive basis, using its strength as a large consumer to assure reasonable costs of care.

An increase in the total number of Medicaid recipients is the second factor contributing to increased program costs. Since 1970, when 52

of the 53 Medicaid programs were in existence, the recipient population has grown by 8.6 million people, from 14.5 million to 23.1 million. This growth is attributable to two factors: an increase in Medicaid recipients due to expansion of the number of people receiving cash assistance under AFDC, and the increase in States providing Medicaid coverage for SSI beneficiaries and the medically needy.

It is only natural that as the Medicaid program becomes more familiar to the general population, its utilization will increase. After 10 years of existence, during which time many who were previously excluded from medical services gained knowledge of and access to health care, public response to its understanding of the Medicaid system is being felt in growth of the recipient population. EPSDT, for example, is contributing to increased utilization as the result of federally-required outreach activities.

Between FY 1970 and FY 1976, the number of adults in families with dependent children on the Medicaid rolls grew from 3.5 million to 5.3 million, an increase of 51.5%. These adults comprise 22.4% of all Medicaid recipients, and receive 17.7% of the program's benefits. During this same period, the number of children under 21 receiving benefits climbed from 6.5 million to 11.1 million, growing by 71%. Many of these children are made eligible by their membership in AFDC families. Children under 21 represent 47.8% of the recipient pool, and receive 17.4% of Medicaid expenditures. Thus, the expansion of the AFDC population has contributed to the growth in the cost and size of Medicaid.

One further factor contributing to the increased number of people receiving Medicaid benefits is the inclusion of the "medically needy" option by 32 States. These States receive Federal matching funds to reimburse medical expenses for patients who cannot afford to pay for medical care, but whose income or resources are too great to let them qualify for cash assistance. The "spend-down" clause in the medically needy option requires that persons receiving assistance under this program must previously have spent personal assets on such care, to a point at which their personal finances are not more than 133% of those eligible for AFDC payments, or a lower level as determined by the State. Medically needy persons thus become eligible for Medicaid by incurring expenses in amounts equal to their "excess income". Since patients in this category usually are in need of extensive care, their impact on the Medicaid program is substantial. 45.2% of Medicaid expenditures went to this group in FY 1976.

Since its inception, three new services have been added to Medicaid benefits. The use of intermediate care facilities (ICF's), EPSDT and family planning have contributed to cost growth of the total budget. The latter two services are required by law.

Intermediate care, which was added to Medicaid options in 1972, is the most expensive of these services. In FY 1975, this service accounted for 17.7% of all vendor payments, costing the program over $2 billion. ICF's absorb many patients that formerly received service in skilled nursing facilities (SNF's). Thus, expenditures for care in SNF's as a proportion of total vendor payments decreased from 30.8% in FY 1968 to 20.1% in FY 1975. Between FY 1968 and FY 1975, the total cost of SNF and ICF care increased from $1 billion to nearly $5 billion, growing from 30.8% to 37.8% of provider reimbursements. Therefore, a portion of the growth of the Medicaid budget can be attributed to the introduction of intermediate care facilities.

EPSDT and family planning services have also contributed to increases in program costs. Family planning was mandated by Congress as a required service in 1972. In FY 1975, this service cost nearly $73 million, or 0.6% of vendor payments. EPSDT was added to mandatory Medicaid programs in 1967. While exact data are not available due to differences in the methods States use to report costs, this service is estimated to have cost between $91 and $213 million in FY 1975, representing 1.8% of provider reimbursement costs.

Besides these new required programs, several States have expanded their coverage in optional areas. Forty-two States now offer clinic services, as opposed to 28 in 1971. During this same period, the number of States allowing prescribed drugs has grown from 45 to 51, while emergency hospital services are now provided by 43 States, up from 17 in 1971. Similar increases in services, such as dental services, prosthetic devices, physical therapy, emergency hospital services, and so forth, have made their impact. In FY 1974, reimbursement for optional services was responsible for 20.1% of all Medicaid expenditures.

The goal of Medicaid has always been to provide access to health care to those who are excluded from mainstream medical benefits. During the late 1960's and early 1970's, attempts to foster this goal were the inclusion of greater numbers of individuals, services, and providers within the confines of the Medicaid program. With the advent of the 1970's, however, the resolution of the problem of increased access was no longer amenable to simple increases in eligibility categories or services offered. Cost considerations have become an important consideration, and the maintenance of integrity in existing programs has become the objective of the management economies.

During its 10 years, the Medicaid program has produced major accomplishments by dramatically improving the financial access of the poor to medical services. In 1964, approximately 28% of the poor had not seen a physician in the previous 2 years; by 1974 that figure had dropped to 17%. It is estimated that one in every five Americans has received

some medical care through the Medicaid program. In 1976 alone, more than 23 million persons received at least one service reimbursed under Medicaid.

To sustain the successes of Medicaid within the framework of cost stabilization, the emphasis of the Medical Services Administration is being directed towards the maintenance of program integrity. Program integrity is the condition wherein Federal and State Medicaid payments are made only on behalf of eligible recipients, only for covered services, only for necessary services, and only in reasonable amounts. Within this broad context, the Forward Plan delineates the strategies and major issues of the Medicaid program. Separate chapters are devoted to Program Integrity and Management, which includes Program Management, Fraud and Abuse Control, Necessity and Appropriateness of Care, and Quality of Care; Eligibility; Reimbursement; EPSDT; and Long-Term Care.

PROGRAM INTEGRITY/MANAGEMENT

EXECUTIVE SUMMARY

The Medical Services Administration (MSA) seeks to maintain integrity in its program by assuring that Federal and State Medicaid payments are made only on behalf of eligible recipients, only for covered services, only for necessary services, and only in reasonable amounts.

Due largely to the State flexibility in the Medicaid program provided by legislation, the maintenance of program integrity is a very complex task. Problems which contribute to program integrity lapses follow.

Medicaid regulations are numerous and complicated; therefore, States are not always clear about what is required of them. State program management also evidences many shortcomings. Many States have historically not had sufficient staff to manage the program, and claims processing and management information systems have not been sophisticated enough to deal with a complex health financing program such as Medicaid. Extremely complex eligibility regulations have resulted in a high error rate in eligibility determinations. Because each State chooses its own methods and rates for provider reimbursement, monitoring has been difficult and inaccurate reimbursements have resulted. Medicaid services are often inappropriately utilized, overutilized, or not utilized in conformity with laws prescribing prior authorizations or physician certification. This can result in large and unnecessary expenditures but also hamper the quality of patient care. Finally, the fraudulent and abusive practices of certain providers have been responsible for substantial unnecessary expenditures. The success of these providers is exacerbated by inadequate State staff resources and management practices which fail to prevent fraud and abuse through good claims editing systems and auditing procedures.

In the belief that improved and accountable State management practices will prevent many lapses in program integrity, SRS and MSA have taken a number of steps. A general systems design called the Medicaid Management Information System (MMIS) was developed to help States improve their automated claims processing and information systems. Matching funds were made available for the development and installation of the MMIS (90%) and for its operation (75%).

In 1972, a major effort began to improve State financial management of its public assistance programs. Fifteen financial review guides were developed and a major technical assistance and monitoring effort was launched. In 1975, a Medicaid Eligibility Quality Control program began to direct attention to the high levels of ineligibility on the Medicaid rolls. A utilization control program was also developed to assist States in assuring the necessity and appropriateness of care being provided to Medi-

caid patients. Finally, a major effort was launched to combat fraud and abuse through monitoring, technical assistance, and the development of fraud and abuse detection techniques. These efforts are being supported by large scale targeted reviews intended to identify problems in those States which account for the largest amount of Medicaid expenditures.

It can be seen that the mainentance of program integrity is a crucial goal of MSA but also a very difficult one. The major issue facing MSA in this area is how to prevent program integrity problems through restructuring, modifying, or otherwise improving the respective elements of program management and control.

Plans for addressing this issue are found in separate components of the program integrity/management chapter: program management, fraud and abuse control, necessity and appropriateness of care, and quality of care. The chapters on reimbursement and eligibility should be reviewed as well.

Program Management

Effective State management is a prerequisite to the maintenance of integrity in the Medicaid program. While attempts to improve State program management have made some impact, they have not solved basic operational problems. MSA believes that structural changes in program management must be initiated if major improvements are to be effected.

There are a number of problems that make a redesigned approach necessary. States historically have not had enough staff resources to effectively carry out program administration and management activities, nor have they generally had the expertise or technical capability to manage a large and complex program such as Medicaid. Further, Federal and State monitoring efforts have concentrated on compliance with regulations as opposed to the actual program performance. Finally, most States have been unable to generate basic data which is crucial to overall program management. A redesigned approach would seek to resolve those problems and at the same time apply several operating principles:

- that States should be responsible for the management of State operations without extensive Federal intervention,
- that States should have a strong role in the design and implementation of technical assistance efforts,
- that the Federal government must monitor State performance to ensure the integrity of the Federal share of program expenditures, and

- o that the Federal monitoring and assistance efforts be implemented without greatly increasing the size of Federal staff.

MSA has therefore developed a four-point management improvement plan which would:

- o increase the Federal match for administrative costs to 90%,
- o create an Institute for Medicaid Management which would be the focus for training needs and the dissemination of technology and knowledge from the Federal government to the States and among the States themselves,
- o develop performance standards for critical State operations, and
- o improve the accuracy and usefulness of program data so that State performance could be more effectively monitored.

The increased administrative match would give the States the capability to hire an adequate staff to manage a complex health-financing system like Medicaid. The Institute for Medicaid Management would give the States the capability to train new and existing staff and to develop and implement needed technology. The performance standards would enable States to evaluate the quality of their programs with those of other States and would enable the Federal government to monitor performance and determine continued State eligibility for the increased match. Improvements in the accuracy and usefulness of the program data could be used to evaluate States' performance.

The development and implementation of this initiative will parallel ongoing efforts to improve the compliance and State management assessment efforts that are considered to be a vital part of the program. While the development of performance standards will eventually alter the means by which State management assessments will be carried out, compliance with regulations will remain a necessary part of the program so long as the current structure and legislative penalty requirements are in force.

Fraud and Abuse

Fraud and abuse by providers in the Medicaid program is a serious problem and one which must be controlled if the integrity of the program is to be maintained. Fraud always involves misrepresentation with the intent to obtain services, money, or gain to which a provider is not entitled, and abuse involves repeated violations of laws and regulations

which results in financial gain. While estimates of provider fraud and abuse vary widely, current indications are that it may be between 8% and 15% of the program, with abuse being the major part of it. Indications are, as well, that the majority of fraud and abuse is carried out by a small percentage of the providers participating in the program. Fraud and abuse practices can range from duplicate billings to providing unnecessary services to Medicaid patients. Inappropriate reimbursement of providers engaging in these practices wastes tax dollars, but at its worst can adversely affect the health of recipients.

A major factor which contributes to varying levels of fraud and abuse throughout the 53 Medicaid jurisdictions is the extent to which those jurisdictions exercise tight management controls over their programs. Because good program management is a prerequisite to fraud and abuse control, the problems which contribute to poor management also contribute to high fraud and abuse levels. A major problem in this area is the complex legislation and Federal and State regulations associated with Medicaid, which not only make monitoring difficult, but which provide an opportunity, for those who wish to do so, to defraud and abuse the system. The wide variation in program design from State to State makes the problem even more difficult from the Federal perspective. Inadequate claims processing systems at the State level and the lack of information systems which provide data on program utilization and provider participation make detection of these practices limited at best. Finally, the lack of staff resources at the State level to carry out fraud and abuse control activities has also inhibited progress.

Another major problem has been the difficulty in prosecuting actual cases of detected fraud. Because fraud is a matter of law, its definition may vary from State to State, and proof of intent is required to obtain a conviction. Since proof often involves massive amounts of evidence, prosecution is exceedingly difficult and time consuming. Legal tradition and the Federal-State nature of the Medicaid program also dictate that redress be sought first in the State and local courts and that Federal prosecution be sought only in exceptional cases or where States do not take action. Abusive practices are even more difficult to prove because a pattern must exist.

Because the responsibility for fraud and abuse control lies primarily with the States, the Federal role to date has been one of monitoring State surveillance activities, providing technical assistance, and providing tools to improve the management of the programs through MMIS and other financial management assistance. However, due to the wide publicity regarding fraud and abuse in the program and growing concerns on the part of the Federal government, the Congress, and the

States, MSA has launched a major five-point initiative to combat the problem. The initiative focuses on the following elements:

- Management efforts to improve claims processing systems, extend the use of audit techniques, and encourage interstate information exchange of best practices,
- Fraud deterrence through the increase of fraud and abuse staff resources,
- Federal-State joint review of high volume States to identify guilty providers and refer them for appropriate administrative action or prosecution,
- Provider-consumer involvement to encourage providers to police themselves and consumers to report suspected fraudulent and abusive actions, and
- Federal agency coordination to encourage coordinated investigative efforts and information exchange with the Department of Justice and the Internal Revenue Service.

Further actions are being taken, such as the exchange of information between the Social Security Administration and SRS about suspected providers. MSA believes that the success of this initiative over the next two years will lay the foundation for more effective, longer range efforts that will enable the States to control fraud and abuse in their own programs and permit the Federal government to serve primarily in a technical assistance role.

In conclusion, it is clear that fraud and abuse in the Medicaid program is a serious problem. While fraud and abuse control is primarily a State responsibility, the magnitude of the problem has warranted a large scale Federal effort which is designed to put in place the management tools, staff resources, and communications networks which are necessary to combat the problem for the longer term. The ultimate objective of this effort is to assure integrity in the program in terms of expenditures, but also in terms of the quality of care provided Medicaid recipients.

Necessity and Appropriateness of Care

Another principle way in which Medicaid fosters program integrity is through the use of variety of mechanisms to assure that the services received by its recipients are necessary and appropriate for their needs; these means include utilization reviews, utilization controls,

medical and independent professional reviews, and professional standards review organizations (PSRO's).

In order to emphasize better State management of Medicaid, Section 1903(g) of the Social Security Act requires States to have a program for controlling the utilization of institutional services in order to receive full Federal matching funds under Medicaid. The law specifies that an effective program for utilization control must provide for a physician's certification and recertification every 60 days that inpatient care is necessary, a physician's plan of care for each patient, a program of utilization review which covers reviews of the necessity for admission and the necessity of continued stay, and a program of medical review by independent professional personnel of patients in skilled nursing facilities (SNF's), intermediate care facilities (ICF's), and mental hospitals. In addition, Federal matching is reduced by one-third of payments for inpatient services for Medicaid recipients after their stays in institutions exceed certain prescribed limits, unless the State Medicaid agency is able to make a satisfactory showing to the Secretary each quarter that it has had in operation an effective program for controlling the utilization of services. Before payment is made for services, mechanisms for controlling the medical necessity and appropriateness of the services must be in place and the State Medicaid agency must be able to assure itself that these are operating effectively. Some States have adopted their own utilization review systems under waiver. As a result of a suit filed by the American Medical Association, regulations covering utilization review of hospitals have been delayed so that public comments can be received and analyzed and any necessary changes made.

In order to fulfill the statutory mandate that the Secretary of HEW validate the assertions of States that they have effective, operating programs for utilization control, surveys are conducted by the Department to establish compliance or, in the case of nonadherence, as a basis for the application of necessary penalties through reductions in Federal matching funds. Surveys conducted in 1974 found many deficiencies in State utilization control operations, but the results were not legally supportable because of regional bias. A new survey is being completed in September 1976. New survey techniques are being developed and staff are being trained in their administration.

Several kinds of problems have become apparent in the present Federal approach to utilization control. To date, the principal effort of the staff has been devoted to the design and conduct of surveys and to the review of State quarterly showings for the determination of adherence and the application of penalties; little time has been available to assist States in the development, implementation, and improvement of their utilization control systems, either the ones prescribed by statute or

alternative ones being experimented with under waiver. In addition, experience indicates that the penalty provisions prescribed by law are too drastic for relatively minor deficiencies in State systems and for those systems which are making rapid progress, but which are not yet complete. Further, the requirements for State quarterly showings and for the utilization review process itself are simply too much paperwork exercises as they currently function for valid utilization control. These kinds of problems point out the need for a reassessment of the Federal approach to and priorities for utilization control.

Utilization control is one of the primary mechanisms by which the Federal and State governments manage the Medicaid program. There are several ways in which the management of the program can be strengthened through more effective utilization control. The Federal role should be shifted away from the current emphasis on the determination of adherence and the application of penalties to increased emphasis on assisting States in the development and implementation of their utilization control programs. Particular attention, encouragement, and support should be given to States to design and evaluate new, alternative systems of utilization review under waiver. Quarterly showing reports should be revised to enable the Department to make more reliable and accurate assessments of the utilization control program within each State. The use of the Medicaid Management Information System as an information base can provide a useful adjunct to these activities. In addition, the sanctions to be applied as penalties need to be made more realistic and redirected from an all-or-nothing approach to a graduated formula in which the penalty amount more appropriately matches the nature and degree of nonadherence. Further, a positive-oriented, incentive approach may well be more effective than the present negative-oriented, penalty approach in realizing desired State utilization control systems. The actual process of utilization review itself should be expanded from its current reliance on reviews of patient records to direct interaction with patients as is done through medical reviews in skilled nursing facilities (SNF's) and independent professional reviews in intermediate care facilities (ICF's). Through the adoption of such strategies to better control the necessity and appropriateness of care received by Medicaid recipients, the integrity of the Medicaid program should be considerably enhanced.

Quality of Care

A highly important component of program integrity is the quality of care received by program recipients. There are several ways in which the Medicaid program strives to assure the quality of care received by its recipients; among these means are requirements for capability

standards for both facilities (such as the Life Safety Code) and practitioners (such as State licensure), performance reviews (such as done by professional standards review organizations (PSRO's), and assuring the sufficiency, comprehensiveness, and accessibility of services.

The first reference to quality assurance was contained in the original Medicaid law in 1965; this law specified that in order to assure quality of care both practitioner services (such as physician care) and institutional services (such as hospital care) are needed. The 1967 Amendments to the Social Security Act expanded the scope of covered services because it was believed that greater comprehensiveness was necessary to assure quality of care.

The legislative development of Medicaid shows a progressive increase in requirements for capability standards for participation in the program. Practitioners must meet the requirements for State licensure and be certified by the appropriate professional and/or legal bodies. Institutional facilities must meet the requirements of the Life Safety Code for the protection and safety of residents and must have available designated types of staff and equipment to assure professional medical capability. For the most part, these institutional requirements have been directed at long-term care facilities and have, as a result, substantially upgraded their quality over the past several years. While such standards do not in themselves guarantee that high quality care will actually be given, they do assure that the capability for providing quality care exists.

A prerequisite for care of good quality is that it be necessary and appropriate for the particular needs of the individual patient. The 1967 Amendments required States to establish systems of "utilization review" in their Medicaid programs. The 1972 Amendments mandated that "utilization control" procedures be instituted in States for all services paid for by Medicaid. Professional standards review organizations (PSRO's) were also authorized and given final authority for determining the medical necessity and appropriateness of care for Medicaid and Medicare reimbursement in those areas where medical societies choose to establish them.

PSRO's are also currently the principal mechansim for performance review of acute (hospital) care to assess quality. Individual PSRO's must develop norms of care and treatment based on professional standards and on the patterns of practice within their geographic area.

While considerable progress has been made in developing and implementing mechanisms for assuring the quality of care rendered to Medicaid recipients, new initiatives are needed to realize this goal further.

Existing requirements for capability standards are probably sufficient, but efforts need to be maintained to see that they are strictly enforced. Emphasis should be placed on determining the most effective means for performance reviews to assess the quality of care. Such reviews should be based on the state-of-the-art standards for each area of professional practice. PSRO's need to be rigorously evaluated in regard to their cost-effectiveness and judged as to whether they are the best or most appropriate mechanisms for achieving the objectives of the Medicaid program. This is particularly true for the area of long-term care where PSRO's have yet to be introduced. The current functions and approach of medical review teams in skilled nursing facilities and independent professional review teams in intermediate care facilities can provide a model for such performance reviews for quality; such reviews emphasize direct patient observation and interaction instead of mere reliance on patient records. In setting up information systems for such reviews, care needs to be taken to avoid duplicating data collected for other program functions; such systems need to be more closely integrated than they presently are. Despite mechanisms for assuring the structural capability for quality care and for evaluating the quality of the care process itself, the "quality of the care" rendered may ultimately have to be judged on the basis of the actual outcomes of the care for the individual patient relative to other possibilities. Accordingly, various techniques for determining the status and well-being of patients on a wide-range of measures need to be developed and tested to compare patient outcomes and alternative modes of care. Assuring the quality of care also entails assuring the sufficiency of resources for care (both financial and health resources) as well as assuring the availability and accessibility of a range of modes of care to best meet the particular needs of individual patients; this is especially important for assuring the quality of long-term care. The provision of education and information to Medicaid recipients on health and the health care system could do much to assure the quality of care they receive through knowledge of the options available to them. Medicaid should also continue to provide encouragement to States to experiment with new means for assuring the quality of care received by its recipients. Through the pursuit of such kinds of strategies, Medicaid should be able to strengthen the integrity of its program by assuring the quality of care for which it pays.

ELIGIBILITY

EXECUTIVE SUMMARY

The Medicaid program seeks to ensure access to health care services for needy individuals who meet certain eligibility requirements. A major problem in achieving this objective is that eligibility specifications are found in over thirty Federal statutes, numerous supporting Federal regulations, and State eligibility policies which vary throughout 53 Medicaid jurisdictions. The result is an eligibility system which is extremely complex and basically unmanageable. This situation manifests itself in a number of different ways.

First, SRS/MSA have been unable to give States definitive policy guidance in a timely fashion in response to their requests. Delays have been caused by the lengthy clearance process in HEW as well as the sheer difficulty in interpreting eligibility policy. States must often proceed without proper guidance and take a chance that they will later be found in error, with potential negative impact on both recipients and State budgets.

Second, many low-income persons are ineligible for Medicaid because they do not belong to one of several categories established by Federal statutes (i.e., AFDC, SSI). These restrictions mean that two persons with identical incomes and medical bills may be treated differently, depending upon conditions other than income or medical need. While this situation raises questions of basic equity, it also results in the expenditure of immense resources in eligibility determination functions and in responding to large numbers of individuals who believe they have been unfairly denied Medicaid benefits.

Third, the flexibility permitted the States in establishing eligibility conditions, such as the medically needy option and specific income criteria, results in considerable fluctuation in State standards and benefits. While there is clear legislative intent to permit such flexibility, the result is a system so complex that it cannot be properly managed. Questions of equity can also be raised.

Fourth, ineligibility rates in Medicaid have been estimated at nearly 20%. This is due in large part to the complexity of the regulations and inability of Federal staff to provide adequate technical assistance to the States. This problem not only has significant implications for the huge costs of Medicaid, but has required the diversion of limited Federal eligibility staff resources from technical assistance and policy development activities to eligibility quality control efforts.

Current efforts at the Federal level to resolve problems within existing legislative requirements involve policy development and technical

assistance. These efforts include policy issue resolutions, regulations development, the development of an eligibility manual, State eligibility reviews to ensure quality control, training and technical assistance workshops for States, and analyses of State eligibility characteristics data.

However, four major issues need to be addressed if significant progress is to be made. The first three issues, which overlap in part, are concerned with eligibility reforms and would require legislative amendments. The fourth is concerned with the effectiveness of current quality control efforts to reduce ineligibility rates. The recommendations are as follows:

- That simplified national Medicaid eligibility criteria be established.

- That financial eligibility criteria be the sole determining criteria for Medicaid eligibility.

- That consideration be given to legislative options that would reduce current inequities in eligibility.

- That the effectiveness of the current quality control efforts be assessed in light of actual accomplishments, best use of limited Federal staff resources, and overall efforts to improve State program management and to simplify eligibility regulations.

In conclusion, MSA believes that major reforms of current eligibility policy are necessary to make significant improvements in the management of the Medicaid program. MSA also believes that it is now time to reconsider the basic issue of who should be eligible for Medicaid assistance and related questions of equity in light of ten years experience with the program.

REIMBURSEMENT

EXECUTIVE SUMMARY

Reimbursement refers to the procedures and mechanisms by which Medicaid pays for the services received by its recipients. Medicaid employs a vendor payment method of financing by which, as a third-party payer, it directly reimburses providers for the covered services they render to Medicaid's recipients. The objectives of Medicaid's reimbursement policies are to assure adequate access to care, to pay for necessary and appropriate services on a reasonable cost or a reasonable charge basis, to assure the quality of care provided, and to contain the rising costs of the program.

Prior to July 1, 1967, the method of reimbursement for Medicaid-covered services was discretionary with each State. However, in order to meet the mandate of the 1967 Amendments to the Social Security Act that Medicaid's payment for inpatient hospital services must provide for the reasonable cost of such services, the Secretary opted to require States to use Medicare's principles for cost reimbursement; these principles require that each facility be reimbursed all necessary and proper costs in the provision of care for program recipients. In order to give States more flexibility in determining methods of payment, Medicaid's regulations were amended in 1970 to allow States to adopt alternative methods of payment for inpatient hospital services; to date, only four States have done so (California, Colorado, Massachusetts, and New York). In order to provide a check on rising costs, the 1972 Amendments to the Social Security Act provided for the grouping of hospitals by geographic area and size and for the establishment of limits for each group on the per diem costs for room and board and for general routine services which would be paid for by Medicare and thus by Medicaid in those States which use Medicare's formula.

For services other than inpatient hospital services, the 1967 Amendments specified that payment could not exceed "reasonable charges consistent with efficiency, economy, and quality of care". However, in December 1972, P.L. 92-603 required that States must pay for institutional long-term care services (i.e., skilled nursing facility (SNF) and intermediate care facility (ICF) services) on a reasonable cost basis as of July 1, 1976; the corresponding regulations permit grouping of long-term care facilities on a class basis and allow reimbursement ceilings to be set on the basis of average costs or of standard costs. For physician services, current regulations allow States to specify the method and the amount of payment, but the physician charges recognized cannot exceed payments which would be made under the methods of determining reasonable charges in effect under Medicare. Under current Medicaid regulations, payments for laboratory services may be made up to a ceiling established on the basis of "prevailing charges in the locality for comparable services under comparable circumstances". The "Maximum Allowable Cost" (MAC)

drug regulations establish a maximum allowable cost for selected multiple source drugs through the use of estimated acquisition costs instead of average wholesale prices and provides for the selection and clearance for bioequivalency of a sizeable number of drug items.

Several significant problems have developed during the course of Medicaid's financing of health care for the poor. Reimbursement is one of the key program instruments by which Medicaid can most effectively deal with such problems as it is the mechanism by which the flow of Federal money is controlled.

In the area of inpatient hospital services, rapidly rising program costs have been the principal concern at both the Federal and State levels. Medicaid expenditures for inpatient hospital care have risen from $913 million in FY 1967 to $2,288 million in FY 1971 to $3,915 million in FY 1975. Current Federal reimbursement policies under Medicare and Medicaid have been inadequate to hold down the major increases in costs for inpatient hospital care. Even those four States which have adopted alternative Medicaid reimbursement systems for inpatient hospital care have been unable to hold down total expenditures for such services. At both the Federal and State levels, hospital costs are quickly overcoming the fiscal resource capacities of governments to pay for them. In response to this threat, Medicaid is working closely with other parts of the Department to formulate both short-term and long-term cost containment initiatives which will deal with the industry-wide problem. However, in addition, Medicaid is pursuing the development of strong measures to gain control of such costs within its own program through its reimbursement policies. To do so, Medicaid is moving toward the adoption of a "prudent buyer" strategy for the purchase of inpatient hospital care for its recipients. Such a strategy would be based on the institution of a prospective system of reimbursement to replace the current system of retroactive reimbursement. The design of such a system would take advantage of the knowledge and experience gained in States which have experimented with alternative forms and means of prospective reimbursement. A "prudent buyer" strategy would also entail the specification of standardized products of hospital care so that determination of reasonable rates for such products can be made prospectively within a given geographic area. The establishment of such a system would provide competitive incentives for hospitals to contain the costs of the services they render relative to each other and thus minimize the costs to Medicaid.

In the area of long-term care (LTC), a combination of rising costs and provider fraud and abuse have been the chief concerns. The investigations of Congress and the New York State Moreland Act Commission have uncovered widespread fraudulent and abusive practices by proprietary owners, particularly in the quality of care provided and in the sale and

resale of facilities. Overall, the costs to Medicaid for institutional LTC have risen from $766 million in FY 1967 to $2,183 million in FY 1972 (when intermediate care facility services were transferred to Medicaid) to $4,650 million in FY 1975. The recommendations of the New York State Moreland Act Commission can help Medicaid States design more effective capital and quality-of-care provisions into their current reimbursement policies for greater control of these service components. More broadly, Medicaid is developing mechanisms for financing more integrated LTC at lower cost. Such mechanisms would incorporate some form of prospective reimbursement and a "prudent buyer" strategy so that the LTC services purchased would better fit the needs and circumstances of program recipients within their local area.

To assure adequate access to physician care while concurrently controlling its utilization and cost, Medicaid is continuing to encourage States to be flexible in the methods they adopt for physician reimbursement and to experiment with alternative modes of financing such services.

Widespread fraud and abuse has also been documented in the clinical laboratory industry. Medicaid is assisting the States in the reform of reimbursement policies to increase control of clinical laboratory services to prevent fraudulent and abusive practices, to assure the proper utilization and quality of these services for recipients, and to contain the cost of such services relative to other components of care. To do so, Medicaid wishes to pursue a strategy which takes advantage of the economies of scale to be gained in the mass processing of such services on an area-wide basis and which affords the means for more centralized control of these services for program recipients.

In order to achieve the maximum cost savings in program expenditures for prescribed drugs, Medicaid needs to vigorously implement both the "Maximum Allowable Cost" drug regulations and a comprehensive program of drug utilization review. Such a program would include greater use of automated systems to produce data for retrospective review, provider education on prescribing, use of formularies, patient education on the use of prescribed drugs, cost sharing, more use of patient profiles, and active drug committees.

Through the pursuit of such strategies in its reimbursement policies, Medicaid will be able to assure that necessary and quality care is provided its recipients while maximizing the efficient use and purchasing power of the dollars expended.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

EXECUTIVE SUMMARY

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program seeks to fill the need of poor children for better health care through preventive and treatment services to children under 21 who are eligible for Medicaid. While the effectiveness of EPSDT will eventually be judged against criteria such as the reduction of chronic and disabling conditions in the target population, the current stage of program development requires the removal or reduction of barriers which impede the implementation of a functioning program within each State.

There have been a number of major accomplishments in implementing EPSDT in the past two years. The volume of screening services provided to children has increased significantly. A number of States have taken steps to ensure that initial screening is actually followed by diagnosis and necessary treatment. Several States have spontaneously developed variations in service delivery. A technical assistance contract to provide States with professional and medical assistance in EPSDT program implementation has been successful.

Many States have responded to the threat of penalty assessments by making positive program modifications. Communications between the Federal government and the States have increased, particularly in connection with the revision of penalty regulations. Penalty reviews have been reduced to two a year for those States which are not penalty liable, thereby freeing up time for positive program development activities. Positive program development assistance has been initiated by the Federal government through State Analyses to identify barriers to program implementation, and the development of Program Improvement and Technical Assistance plans.

However, there are still significant problems. Certain States and local jurisdictions do not yet have a program which meets minimal Federal requirements. Other programs are mismanaged or badly planned. Insufficient staff resources at the State level contribute to weak programs. There are major problems in implementating a high quality service delivery program beyond the minimum requirements. Screening services are often not linked to diagnosis and treatment services. Fragmentation results from lack of coordination between the Federal government, States, and local jurisdictions in programs which relate to children. Weak case management capability in many States results in a lack of follow-up after referral from screening, with little assurance that diagnosis and treatment take place after referral; inability to assure periodic rescreening; lack of control over inappropriate screening; and insufficient data to plan, manage and evaluate the EPSDT program. The lack of basic data is a major barrier to full program implementation.

Provider shortage and maldistribution, inadequate program resources, and, in many cases, access to available resources are also problems. State fears about potentially high costs have made them reluctant to conduct aggressive outreach programs to advise recipients of the program and its benefits. Finally, the lack of health education programs and lack of recipient understanding about preventive medicine and health care has resulted in a high rate of no-shows for screening and treatment services as well as a tendency toward high cost crisis rather than preventive treatment.

Current problem-solving efforts center around positive program development activities; continued penalty assessments; and knowledge development. Positive activities include direct technical assistance to States through contract; State Analyses, and the development of Program Improvement and Technical Assistance plans; dissemination of best practices; support to States to build local-level outreach, follow-up, and case management ability; implementation of a model EPSDT management information system; interagency coordination and planning efforts related to the EPSDT developmental assessment component.

The penalty assessment process includes improvement efforts to make the process fair, equitable and meaningful; the publication of revised regulations; and the removal of basic obstacles to program implementation to ensure that a State can meet minimum penalty requirements and still have a good quality program.

Knowledge development will focus on revisions to statistical reporting requirements and knowledge expansion in the following areas: (1) problems related to the older child in EPSDT; (2) developmental assessment and treatment; (3) the role of the school in EPSDT implementation; and (4) interagency collaboration.

The major issue facing the EPSDT program at this time is the means by which MSA can provide incentives to States to encourage full program implementation. Five issue papers have been developed which recommend the following:

- That the Federal match for EPSDT services and administration be increased to 90%.
- That the Federal match for mandatory dental services be increased to 90% for three years or until the backlog of unmet need in the States is reduced.
- That recipient eligibility be extended where necessary for four months to ensure the completion of treatment programs begun under EPSDT.

- That a separate appropriation be provided for research and development, capacity building grants, start-up funds, and manpower training for EPSDT.

- That consideration be given to permitting advance funding to States for EPSDT expenditures to cover high cost capital items.

In conclusion, the major objective of the EPSDT program is to reduce the barriers to full program implementation through positive program development activities, continued penalty assessment, knowledge development, and financial incentives to States. Since EPSDT can be considered as a prototype for National Health Insurance, the results of EPSDT implementation will be of significance in the future debate on the issue.

LONG-TERM CARE

EXECUTIVE SUMMARY

Long-term care (LTC) refers to those health-related services provided to persons debilitated by old age, illness, or disability over an extended period of time. Institutional LTC is generally provided in skilled nursing facilities (SNF's) and intermediate care facilities (ICF's); community care is primarily provided through day treatment centers, day hospitals, and home health agencies.

With the enactment of the Medicaid law in 1965, the Federal government provided substantial financial support to the States for the provision of services to low income persons requiring LTC. Subsequent amendments to the law in 1967 and 1972 expanded the scope of Federal requirements for State programs to assure greater quality of care and control of costs.

Currently, States participating in Medicaid must provide skilled nursing facility and home health services for their recipients; intermediate care facility services are optional; day care can be provided as a clinic service. Institutional facilities must meet specified standards for participation, must be periodically inspected, must provide certain information, must have a written plan of care for each patient, and must conduct patient reviews to assure the necessity, appropriateness, and quality of care received. Reimbursement must be on a cost-related basis.

In FY 1975, expenditures under Medicaid for institutional LTC constituted 37.7% of total vendor payments with $2,471 million spent for SNF services and $2,179 million for ICF services; only two years earlier, in FY 1973, 34.2% of total vendor payments under Medicaid went for institutional LTC services. In contrast, expenditures for home health services under Medicaid represented only 0.6% ($69 million) of total vendor payments in FY 1975.

Medicaid has faced many problems in its effort to provide needed LTC services to low-income individuals, particularly for the elderly. Congressional, State, and media investigations have uncovered widespread scandals in the nursing home industry. Exorbitant profits have been extracted at the expense of both the vulnerable elderly and the taxpayers. The quality of care in many LTC facilities has been severely deficient, posing serious threats to the safety, health, and well-being of their residents. The protection of the rights, welfare, and funds of institutionalized LTC patients has been seriously neglected. There have been problems in matching services to the particular needs of LTC patients. The common definition of SNF services for Medicare and Medicaid does not adequately provide for the LTC needs of Medicaid patients.

The level-of-care classification and placement of LTC patients vary widely across States. A number of studies have shown that a substantial portion of LTC patients are either unnecessarily institutionalized or placed at inappropriate levels of care. To a great extent, this reflects the lack of development and support of community-based services, such as day care and home health care, which can prevent, delay, or serve as alternatives to institutionalization. This is also due to the lack of utilization of formal mechanisms to properly assess the total needs of LTC patients and to provide information and assistance for the appropriate placement of such individuals. The pressures of ever-rising program costs for LTC have inhibited the full development of LTC services. In addition, a few States have reacted by reclassifying LTC patients to lower levels of care or, in the case of the mentally retarded, have shifted such individuals from state-supported institutions to Medicaid-supported ICF's.

The basic aim of Medicaid in LTC is to provide support for a continuum of quality services to appropriately and efficiently meet the needs of its recipients. In order to achieve such an objective and to overcome the problems that have been encountered, Medicaid, in conjunction with other parts of the Department, is engaged in a variety of activities. Through the Departmental Regional Office of Long-Term Care Standards Enforcement, State surveys for the certification of LTC facilities on the basis of standards for quality are being reviewd. Medicaid staff are also assisting States in the implementation of the Life Safety Code to assure the safety of institutionalized LTC patients. Medicaid is also actively promoting the use and implementation of medical reviews in SNF's and independent professional reviews in ICF's to assure the necessity and appropriateness of the level of care being provided to LTC patients; in contrast to other types of reviews which look only at patient records, these reviews involve personal contact with and direct observation of each patient by a member of the professional team. New regulations have been developed to protect the rights, welfare, and funds of institutionalized LTC patients. The new, pending home health regulations are designed to stimulate the development of such services while at the same time providing safeguards to control the quality, appropriate use, and costs of these services. Medicaid is also participating in several research and demonstration projects to test various models of and mechanisms for providing community-based services, such as day care. In addition, MSA staff are exploring alternative approaches to the financing and delivery of LTC services to increase flexibility in the use of LTC funds to better fit the benefits and type of services provided to individual and local needs and circumstances, while concurrently strengthening the means of assuring the quality of care and improving the mechanisms for controlling its costs. A promising approach is the development of commmunity care organizations with the responsibility of meeting the LTC needs of residents within their local area. Such organizations would

have the capability of initially and continually assessing the individual needs and care of LTC patients, of stimulating the development of comprehensive LTC services within their area, of monitoring standards of care, of providing guidance for appropriate placement, of packaging needed services for individual cases, and of giving citizens, professionals, and consumers the opportunity for participation in the planning and management of LTC within their area.

The future strategy of Medicaid in the area of LTC is to design and implement more effective ways of controlling program costs for LTC and to encourage the development and utilization of a fuller range of services to better meet the LTC needs of its recipients. To most effectively contain future program costs for LTC, major changes in its financing are required. The current system of retroactive reimbursement and open-ended funding for LTC has no incentives for the provision of services in the most efficient and cost-effective manner. Federal financing for LTC needs to be shifted to a prospective basis so that States and providers must operate under predetermined funding amounts for the provision of LTC services. Similarly, stronger incentives need to be provided to develop a wider range of LTC services, particularly those which are community-based, so that the needs of Medicaid LTC patients can more appropriately be met. Medicaid is actively encouraging States to experiment with mechanisms for better assessing the individual needs and resources of LTC patients, for placing them in the most appropriate and cost-effective care settings, and for developing needed support services in the community. The adoption of these strategies by Medicaid in the area of LTC will assure the provision of necessary LTC services for program recipients at the lowest cost.

PROGRAM INTEGRITY/MANAGEMENT

CHAPTER 1

DEFINITION AND SCOPE

Due largely to the wide latitude provided States in designing their programs, Medicaid has become very detailed and complex. This complexity poses a considerable challenge in view of the need to maintain program integrity. In effect, the States are important and strong partners with the Federal government in operating Medicaid. This partnership causes them to be only indirectly accountable and makes the detection of program abuse difficult. Even the maintenance of current information describing the basic characteristics of State programs is a very difficult and time-consuming task.

Concern for legality and effective implementation coupled with the variation in State programs and accountability problems demand a clear definition of program integrity. Simply stated, program integrity is the condition wherein Federal and State Medicaid payments are made only on behalf of eligible recipients, only for covered services, only for necessary services, and only in reasonable amounts.

Eligibility factors, services covered, mechanisms used to determine if a service was necessary, and rates paid are all being defined by the States, although their definitions will be restricted within broad Federal limitations. The ways in which program integrity is maintained is also a responsibility of the States. The Federal responsibility is to monitor the State's maintenance of program integrity. In this sense, the maintenance of program integrity encompasses almost all State activities that are variously termed program management or administration. For example, it can include: policy setting activities, rate setting activities, the entire claims processing activity (especially edits, audits, and exception reports), payment screens which are built into the claims processing system, post-payment review activities, eligibility determination, the method by which recipients receive and use Medicaid cards, the method by which providers are enrolled, the methods by which providers are screened, and so on.

As can be seen by the above narrative, the maintenance of program integrity is a major goal which cuts across all levels of the program. Four activities directed toward maintaining program integrity - program management, fraud and abuse control, utilization control (necessity and appropriateness of care), and quality of care - are discussed as separate components of this chapter. Other activities such as eligibility operations and reimbursement policies are discussed in detail as separate chapters, although they will be referenced throughout this chapter.

PROBLEMS

Amid the complexity and indirect accountability of Medicaid, many problems have become evident which indicate that not all States are adequately maintaining the integrity of their programs. These problems are often difficult to detect and document since Medicaid transactions are typically small in amount and number in the millions in large States. Medicaid recipients are large in number (24 million estimated for FY 1977), and the evidence must be located among a huge volume of claims and eligibility forms.

Because of this reality, valid data describing the nature and magnitude of program integrity problems in all States is not in hand. However, appreciation of the great size of Medicaid ($16 billion projected for FY 1977), any gap in program integrity would be extremely costly to the taxpayer.

Several serious problem areas can be recognized even in the absence of reliable field data.

- Medicaid regulations are numerous, difficult to understand and complicated. Much of this is due to the legislative structure of the program. However, States' difficulty in comprehending what is required of them makes the maintenance of program integrity within the States much more difficult.

- Program management evidences shortcomings in many States. Many States traditionally have not had sufficient staff to effectively manage the program. Claims processing systems are often times poorly controlled, pay claims slowly and exhibit high error rates. Edits, audits and pre-payment reviews are sometimes ineffective and exception reports are not generated. State program managers often have an unclear understanding of their own program regulations, especially with respect to eligibility and reimbursement. State programs often fail to generate even the most basic management reports (such as the number of recipients served) and there are notable lapses in State reporting of management data to the Federal level. Pre- and post-payment reviews are sometimes perfunctory, ineffective or lacking altogether. There are few, if any, standards by which States and the Federal government can measure the performance of the respective programs.

- Medicaid eligibility regulations probably rival all other Federal rules in complexity. All AFDC cash recipients are automatically eligible for Medicaid. The error rates in determination of AFDC eligibility can be unacceptably high and these errors, of course,

carry over into Medicaid. All SSI recipients (except those in "209 B" States which opted for a more restrictive Medicaid eligibility standard when SSI replaced pre-existing State-run programs to assist the aged, blind and disabled) are also automatically eligible for Medicaid. The error rates in SSI eligibility determination would appear to be placing even more Medicaid ineligibles in a position to receive services. In addition, 32 States have medically needy programs which cover the aged, the disabled, and mothers with children whose incomes are high enough to make them ineligible for SSI or AFDC but are within levels set by each State. General Accounting Office (GAO) audits of State medically needy programs have measured ineligibility rates in excess of 28%. Such a finding is not surprising since the recipients are, by definition, working and their incomes tend to fluctuate from month to month.

- Provider reimbursement is another area of considerable complexity, with each State choosing its own methods and rates. In addition, many State reimbursement systems pay variable rates to different providers for essentially the same service. Such variable reimbursement is very difficult to audit. It is apparent, however, that difficulty with monitoring reimbursement contributes to problems of inaccurate reimbursement.

- Medicaid services are often inappropriately utilized, overutilized, or not utilized in conformity with laws prescribing prior authorizations or physician certification. Some of the more blatant and consistent overutilization is defined as program abuse. The utilization problems which do not appear to be part of a pattern of illicit financial gains appear rooted in the inefficient and poor management of a patient's progress. Whatever its basis, however, it can account for large and unnecessary expenditures of program dollars.

- Actual provider fraud and abuse are even more serious problems. The degree to which fraudulent and abusive providers succeed in obtaining reimbursement to which they are not entitled is worsened by aforementioned problems such as poor State management (especially of claims processing), poorly articulated regulations, the lack of post-payment review, and poorly monitored reimbursement. The mere number and variety of providers makes it difficult for the State to scrutinize the claiming patterns of any but a relatively small number. Even the review and audit of nursing home cost reports is typically neither intensive nor timely, and is sometimes little more than perfunctory.

Evidence that fraud and abuse are substantial is contained in audit findings from the HEW Audit Agency as well as GAO. State investigators have also become more active and more successful in obtaining convictions for various frauds. For the quarter ending September 30, 1975, the States report convictions of 34 providers, referrals of 52 new cases to law enforcement agencies, initiation of 700 new investigations, recovery of $156,800 from both prosecution and administrative action, and 111 suspensions or terminations of providers. Although the accuracy and comparability of this data is questionable, increased recognition of fraud and abuse is a clear trend.

ACCOMPLISHMENTS AND CURRENT STATUS

In order to improve overall State program management, SRS and MSA have focused on several specific areas in the belief that effective and accountable State management will prevent many lapses in program integrity. A primary tool of State management is the claims processing system, and Administration and Congressional attention has been concentrated on the need to provide incentives for the States to improve this resource.

P.L. 92-603 amended the Medicaid statute to provide that States that wish to establish improved automated claims processing and information retrieval systems could receive:

- 90% Federal matching for their development and installation, and

- 75% Federal matching for their operation.

To provide a model for States, SRS developed a general system design called the Medicaid Management Information System (MMIS). An operational MMIS provides the State with the capability to "front end" many of the management problems and poor payment practices that denigrate the integrity of the program. Two modules of the recommended systems design, the Surveillance and Utilization Review Sub-system (SURS) and the Management and Reporting Sub-system (MARS), provide data on the cost and utilization of services, which is essential to the detection of potentially fraudulent or abusive providers and to management information on areas of suspected program integrity lapses. Although State implementation of these improved systems has been fraught with difficulty, 11 States have systems in place, 24 States are in various stages of development or installation, and 7 additional States are preparing plans for developing systems in 1975.

In 1972, the Social and Rehabilitation Service initiated an effort to

improve the financial management of its public assistance programs. This effort was designed to provide technical assistance to the States and to monitor the States financial management of their programs to ensure that claims for Federal reimbursement are made in accordance with Federal law, regulations and an approved State plan. Personnel are located in each of the ten Regional Offices and outstationed in certain of the larger States to perform this function. To assist the Regional personnel in monitoring a State's financial management of the Medicaid program, fifteen financial review guides have been developed. Financial reviews of the State's procedures for claiming Federal funds are performed by the Regional personnel and by contractors under the direction of the Regional staff with a uniform and comprehensive set of procedures for reviewing State management and accounting practices. Where deficiencies in a State's procedures are found, the State is notified of the finding and given guidance to correct the situation. Action is also taken to recover any Federal funds which have been inappropriately claimed.

In addition, States must submit quarterly statements of expenditures claiming Federal reimbursement. Regional personnel inspect State records supporting the claims made on the statements. Claims which are determined to be improper are not allowed for Federal reimbursement.

A technical assistance contract was awarded in 1975 to Control Analysis Corporation to help States on a voluntary basis, identify weaknesses in their systems for controlling erroneous expenditures. This effort has been very successful with 8 State Reviews completed and 5 more planned.

In 1975 as well, the Medicaid Eligibility Quality Control Program, which is modeled upon the AFDC Quality Control Program, was begun with the publication of a Medicaid Program Regulation (45 CFR 205.25), which requires each State to establish Medicaid Eligibility Quality Control. Under this program, each State must select and review a statistical sample of paid claims and from this review identify: (1) the level of ineligible recipients; (2) the associated amount of erroneous expenditures; and (3) their causes and required corrective actions.

In an effort to complement the quality control program, SRS has also developed several eligibility training manuals, is holding a series of multi-Regional training sessions for Regional and State staff, and is conducting on-site State reviews. The purpose of these State eligibility reviews is twofold: to monitor State performance for effective implementation and to help the States improve their eligibility practices and systems.

A Utilization Control program was developed for the purpose of aiding States in putting into place a system of controls to assure that only

those services which are necessary are provided to those who require them, for only as long as they are required and in the setting most appropriate to their needs.

Two national on-site validation surveys have been completed which identified a number of problems in States' utilization control programs. Although no penalties (allowed under Section 1903(g) of the Medicaid statute) have been imposed, Regional staff report that States have made substantial improvements in their programs. Those programs eventually will be supplemented by Professional Standards Review Organizations (PSRO's), some of which have begun to conduct hospital utilization review activities. In 203 designated areas there are already 85 conditional PSRO's which are performing review and another 33 in the planning stage which will soon be ready to assume review responsibilities. These efforts will aid the States in closing the gaps in program integrity stemming from the improper utilization of services.

In order to allow a specific focus on fraud and abuse, which requires a thorough knowledge of the program as well as a firm understanding of criminal procedures and investigative techniques, a separate Division has been established in the MSA. The function of this Division is to improve State fraud and abuse surveillance through monitoring, technical assistance, technology transfer, and the development of detection techniques.

Through contract support, an evaluation of State fraud and abuse systems has already begun. Nine of the largest States have been reviewed and relevant State statutes examined and catalogued. Also with contractor support, audit guides designed to measure the extent and prevalent types of fraud and abuse have been developed and field tested in 3 States. These guides show that a standardized methodology of comparing claims to records is feasible and does detect a large number of potential fraud and abuse in a framework designed to motivate corrective action. This detection tool should prove valuable to both State and Federal auditors. SRS has also learned a great deal about the types of provider fraud and abuse and about the methods required for both its detection and prevention. It remains clear that strengthening State surveillance systems, a more systematic selection of providers to be reviewed, and improvement in State "front-end" management are the results that will shore up Medicaid program integrity as it relates to abusive payments to providers.

In conclusion, it can be seen that the maintenance of program integrity is not only a primary goal of MSA, but one which is fraught with difficulties. Only through the concerted efforts of all individuals,

groups, and organizations responsible for and affected by the Medicaid program, will that goal be achieved. Further details on plans for assuring program integrity are found in the following components of this chapter: program management, fraud and abuse, necessity and appropriateness of care, and quality of care. The chapters on reimbursement and eligibility should be reviewed as well.

DEFINITION, SCOPE, AND BROAD OBJECTIVES

Medicaid seeks to provide necessary medical care for eligible patients when needed, by appropriate providers, in adequate amounts and in a manner which is as economical as possible, compatible with efficient, effective, and proper administration of the Medicaid program. To achieve the objectives indicated by such a mission there must be a system of effective program management which controls and directs ongoing activities (primarily at the State level) through decentralized techniques to organize the delivery and to finance the purchase of personal health services for eligible individuals.

CURRENT STATUTORY REQUIREMENTS

The responsibility for program management is based in the following statutory provisions, some of which overlap into areas of concern discussed elsewhere in this chapter.

Section 1112 provides the Secretary authority to develop and revise guides or recommended standards as to level, content, and quality of medical care and services.

Sections 1902(a)(6), (20), and (24) require States to keep records and make reports as the Secretary directs.

Section 1902(a)(4) provides for the establishment and maintenance of a merit system to provide proper and efficient administration of the State plan.

Section 1903(a), (b), (d), (f), (g), (h) provide for State fiscal reports and control by the Secretary over the Federal financial participation in State Medicaid programs, eligibility standards, and utilization control.

Section 1904 provides Secretarial authority to withhold payments to States that fail to comply substantially with Section 1902 (State Plan).

Section 1909 provides corrective action in instances of fraud and abuse.

During the first decade of Medicaid's existence, there has been a steadily growing appreciation by the Executive Branch, Congress and States that Federal and State management of the Medicaid program must be vastly improved. As indicated earlier, from the onset of the Medicaid program there have been numerous problems which have made program management extremely difficult. While a number of steps have been taken, such as the development of the MMIS and financial review guides, as well as eligibility QC efforts, basic operational problems have not been solved. Federal efforts have usually been reactive and have addressed State operations on a function-by-function basis rather than as an integrated, State managed system. While these responses have not solved Medicaid's operational problems, the responses were, most likely, the best possible response at the initial stage of Medicaid's development.

At the State operational level, Medicaid is a relatively new, highly complex system which employs high technology processes. It is not unreasonable that it has taken 10 years for the Medicaid program, which has undergone periodic and major program changes, to develop the processes and technology that are needed to achieve program integrity.

It has also taken a decade for the development of a consensus by States, Congress and the Executive Branch, both on the magnitude of the problems and on the philosophical constraints on possible solutions. The principles that must be applied to any short run solution are:

- that States should be responsible for the management of State operations without extensive Federal intervention,
- that States should have a strong role in the design and implementation of technical assistance efforts,
- that the Federal Government must monitor State performance to ensure the program integrity of the Federal share of program expenditures, and
- that the Federal monitoring and assistance efforts must be implemented without greatly increasing the size of the Federal staff.

During the past year, Congress, the Executive Branch and many States have proposed drastic and often radical solutions to Medicaid's problems. These proposed solutions reflect the belief that present efforts, continued at their current levels, will not solve the operational problems in the Medicaid system. While each component of the present activities has merit on an individual basis, the cumulative effect of these components has not, and probably will not, solve the basic causes of inadequate State management. In fact, last year MSA stated

that the present activities would succeed only if a stronger mandate for Federal intervention and approximately 750 new Federal staff were granted. These resources were not granted then, nor are they likely to be granted in the future. Therefore, a redesigned approach that will achieve program improvement within resource constraints is now needed.

CURRENT STATUS

MSA has designed a Management Initiative which addresses the basic problems of the Medicaid system in a manner that will preserve the proper roles of the Federal/State partnership and can succeed within existing resource constraints. The responsibility for State problems rests at both the Federal and State levels. The Federal level has not clearly specified acceptable performance standards for critical program operations, nor has SRS/MSA sufficiently aided the States in developing the quality and quantity of staff and the technology needed to reach the acceptable standards.

The four point management improvement initiative would provide States with the quantity and quality of resources needed to effectively manage their programs and would hold them accountable for their management performance. The initiative's major components would:

- enable States to hire an adequate number of staff by raising the match for administrative costs to 90%,
- create an Institute for Medicaid Management which will be the focus for training needs and for the dissemination of technology and knowledge from the Federal government to the States and among the States themselves,
- develop performance standards for critical State program operations, and
- improve the accuracy and usefulness of the program data so that States could improve program management and so that SRS/MSA could more effectively monitor State performance.

Before describing each component of the initiative, the inter-relationships of the components should be stressed. The increased administrative match will give States the capability to hire a staff adequate to the task of managing a complex health-financing system like Medicaid. The Institute for Medicaid Management will give States the capability to train new and existing staff and to develop the technology needed

by this staff to actually improve State performance. The performance standards will enable States to evaluate the quality of their programs with those of other States. In addition, the standards will be used by the Federal Government to monitor State performance and to determine continued State eligibility for the increased match. Retaining the match will be dependent on a State's meeting the performance standards. Improvements in the accuracy and usefulness of program data are needed for evaluating States against the performance standards.

Increased Administrative Match

Increasing the Federal match for State administrative expenses to 90% recognizes that most States do not have an adequate number of staff to perform critical management functions and that local political realities prevent States from solving this problem by themselves.

State and Federal officials agree that there is a shortage of well-trained staff at the State level. State Medicaid Directors are aware of most of their operational problems, but they are often unable to acquire the staff necessary to carry out an effective attack on those problems. Two examples of areas in which Directors realize they can save State and Federal dollars, but cannot hire the staff to achieve the savings, are third-party liability recovery and fraud and abuse control. Historically, States have been forced to respond to new Federal or State priorities by moving staff off earlier priorities, even though the earlier priority remains a critical program operation.

Medicaid administrative costs are a small percentage of total program costs, approximately four and a half per cent. This proportion has remained stable for the last three years -- while operational responsibility in areas such as third-party payments and fraud and abuse have greatly expanded. The cost/benefit of adding staff to these functions is high; however, the political climate in most States precludes most State funded increases, regardless of how necessary. In the past, increasing the Federal matching rate (e.g. EPSDT and the Medicaid Management Information System) has allowed States to obtain additional staff while holding State costs constant.

Raising the Federal match to 90% would increase administrative costs in the short term, but should not produce any long run additional costs. At present most functions are matched at 50% and some special categories are matched at 75%, 90%, or 100%. The continued receipt of the increased match would be tied to a State's meeting the performance standards developed by SRS/MSA. Unless a State's program performance improved, the increased match would be withdrawn.

Institute for Medicaid Management

Permitting States to hire additional staff would not, by itself, enable States to substantially improve their performance. This staff must have the requisite skills and technology needed to manage an operationally complex health financing system which requires sophisticated technology and processes. SRS/MSA has designed a centralized staff training and technology transfer program which would be under joint Federal and State control. This locus for the development and exchange of training and technology for State use is currently titled "The Institute for Medicaid Management".

Two factors dictate that there should be a central knowledge-gathering and dissemination function for Medicaid. First, one State should not be expected to finance the development of the knowledge and/or technology needed by all States. Second, many States have developed successful management practices on their own which could be very helpful to other States. However, the States which developed these advanced practices do not have the resources to disseminate information about these practices to additional States.

While the program should be centralized, it must be heavily influenced, if not managed by the States. The States are in the best position to define their training and technical assistance needs and to develop applicable solutions. The States would have a strong role in the establishment of the Institute's policy, the identification of its priorities, as well as its operation. The Board of Directors for the Institute, for example, could consist primarily of State representatives. By giving the States the major responsibility for the Institute's operation, the Institute's efforts would respond to State needs and therefore impact more directly on program management and the ability of the States to achieve performance standards.

The primary functions of the Institute would be as follows:

- to develop and disseminate training courses, materials, and related packages to meet State defined general training needs as well as to solve specific training problems,
- to train State employees, who in turn could carry out training at the State level,
- to provide or arrange for the loan of Federal or State staff with specialized expertise to States needing assistance in special areas,
- to identify and disseminate information about successful management practices,

- o to stimulate regional and national conferences where State Directors exchange information about problems and solutions,

- o to sponsor seminars on special subject areas of interest to States or to communicate policy changes, etc.,

- o to evaluate advances in hardware and software training technology and advise States of their availability and applicable uses,

- o to develop a demonstration center which would produce instructional materials too costly for States to produce themselves,

- o to arrange for the provision of specific technical assistance by contract where necessary to meet a State's management problems.

The establishment of an Institute for Medicaid Management can thus provide the impetus and resources to meet the training and technical assistance needs of the States, while extensive involvement by the States will ensure that the efforts of the Institute will be directly beneficial to State program management and therefore quality.

Performance Standards

In addition to providing States with the opportunity to have adequate, properly trained staffs and adequate technology, SRS/MSA believes that the initiative must create a Medicaid system with an incentive structure which will motivate States to achieve measurable program performance improvements. This incentive structure can be created by developing performance standards and then tying the retention of the increased administrative match to meeting the performance standards. In addition, the rankings against these standards, which will be available to the public, will allow States to compare their performance with comparable States and will allow the Institute to identify which States have advanced practices or technologies.

SRS and MSA appreciate the hazards involved in establishing quantifiable performance standards, and therefore have initiated appropriate feasibility studies. This work will identify candidate areas most amenable to performance standards and will develop a process for measuring achievement of the standards.

This preliminary work will ensure that:

- o appropriate standards are selected. The wrong performance standard can easily detract from, rather than contribute

to, the program goals. Furthermore, a standard might appear to be on target at first blush, but its interaction with other Medicaid regulations could cause all sorts of aberrant responses.

- o the measurement of performance is controlled. When rewards and penalties stem strictly from measurements reported by the performer, there is an incentive for distorted measurements to be given. This aspect will be closely tied to the data improvement portion of this management initiative.

- o performance standards meet legal acceptability. The recent court decision on quality control emphasized that standards have to be free from accusation of being arbitrary and capricious.

- o performance standards receive political acceptance. This can be achieved by including States, providers and recipient groups in the development of standards.

- o an increased regulatory divergence from Medicare is tolerated if necessary. The establishment of performance standards implies providing the performers (States) with the necessary flexibility to manage their operations to achieve the standards. Medicaid regulations on utilization control and reimbursement are two examples of areas where such flexibility might need to be given.

The development of performance standards should provide an incentive for States to use the new staff and the Institute to actually improve performance. Additionally, it will alleviate the need to substantially increase Federal staff for compliance monitoring.

Data Improvement

The long-standing Medicaid data problem must be solved before States can achieve effective management and before SRS/MSA can implement the monitoring through performance standards strategy. State generation and use of program data has been, and in most States still is, weak. Since the Federal system relies on aggregating State data, the Federal data base has also been inadequate for effective compliance monitoring.

In 1970, the Senate Finance Committee and an independent DHEW task force in the McNerney Report stressed the need for Federal efforts that would encourage State adoption of effective information systems. The reports by the Senate Committee and the McNerney Task Force recognized

that States could not control their eligibility rolls or payment systems without adequate information systems. They also recognized the need for timely compliance data at the Federal level. To encourage more rapid State progress, SRS developed a general system design (the MMIS), SRS/MSA started a technical assistance effort, and Congress raised the match for MMIS developmental and operating costs. While progress has been made, many States have not yet created an effective management information system.

During the past year, SRS/MSA has started activities which are improving the accuracy and usefulness of management and compliance data. Currently available State reported statistical data has been reformatted to facilitate State comparisons. A standard set of descriptive information on each State program has been created and will be automated during the coming year. SRS is presently speeding up the certification process for MMIS, simplifying its general system design, and providing State-specific technical assitance to incrementally improve State systems. These efforts must receive continued support and be closely monitored to ensure that every State implements an effective information system. In fact, the feasibility study for performance standards will determine if the creation of an effective management information system should be the first performance standard.

Compliance Monitoring and Management Assessment

As a final point in the discussion of MSA's management initiative, it should be noted that while the initiative seeks to restructure existing SRS/MSA efforts to provide States with technical assistance and to monitor performance, the Federal government must still continue monitoring State compliance with Medicaid regulations as well as carry out management assessments of individual State systems for administering Medicaid.

Compliance monitoring presents its own set of problems in that there are now some 93 program regulations, many of which are very complex. Traditionally, the Regional Offices which have responsibility for compliance monitoring have not had the extensive resources needed to fully carry out the function. Since the institution of a formal compliance identification system in 1969 through the period ending December 1975, approximately 1,100 compliance issues have been reported. It is estimated, however, that there are far more compliance problems than those identified. This belief is supported by the results of uniform nationwide compliance reviews that have been conducted in special categories. For example, a 1971 review of all State nursing home programs indicated that all but a few States were out of compliance with one or more of the requirements, yet before that point, very few problems had been formally reported.

Congress has expressed disapproval with the manner in which HEW has been monitoring and enforcing States' compliance with regulations, and has instituted provisions which call for the assessment of financial penalities against States which do not comply. However, the process involved in carrying out penalty assessments is very lengthy and time consuming and is difficult to accomplish. The General Accounting Office has also criticized the present compliance process, and a recent HEW Health Penalty Task Force has proposed a number of recommendations for reforming the system.

The Division of Program Monitoring has prepared an issue paper which explores several strategies for handling the compliance monitoring problem. The paper recommends that MSA perform annual in-depth compliance reviews of selected Medicaid areas using standard guidelines. Priority would be given to those compliance areas which have the greatest impact on the care and services provided to Medicaid recipients. While this approach would not cover all compliance issues, it would concentrate limited resources on the most important areas and would permit the identification of non-compliance patterns throughout the States in specific areas. This in turn would give better indications of needs by the States for technical assistance as well as needs for regulations simplification or modification.

In conclusion, while MSA plans to improve existing efforts to ensure effective program management through compliance monitoring and management assessments of selected States, MSA believes that basic structural changes in program management are needed to make more significant improvements. The four-point management initiative proposed by MSA is designed to make those needed changes.

DEFINITION, SCOPE, AND BROAD OBJECTIVES

The Medicaid fraud and abuse control program focuses on the monitoring, identification, and investigation of provider fraud and abuse in the Medicaid program. The determination to focus on provider rather than recipient fraud and abuse is based on the judgement that resources are better spent on individual providers whose extent of fraud and abuse may cost the program several thousands of dollars, rather than recipients, whose fraudulent or abusive actions are less expensive to the program. In addition, most recipient fraud is related to problems in determining eligibility, which is discussed in a different chapter.

Fraud always involves misrepresentation with the intent to obtain services, money or other gain to which one is not entitled. Fraud is specifically defined by the laws of the appropriate Federal and State jurisdictions and the determination that fraud has been committed is always made by a court of law. Typical examples of fraud are billing for a service that was not rendered, billing for a more costly service than that actually rendered and false statements on an institutional cost report.

Abuse involves repeated violation of State and Federal laws and regulations. Abusive practices adhere to a pattern but lack either demonstrable intent or false statement. Abuse, however, leads to a provider's obtaining reimbursement which is not entitled under Federal and State laws and regulations. Typical program abuses include blatant over-utilization of services and overcharging.

To distinguish abuse from care that is unnecessary or of inferior quality, one must view an abuse investigation as focusing on a provider's pattern of practice and resulting financial gains rather than on whether a particular service was appropriate to the individual patient's diagnosis and treatment regimen, which is the focus of Utilization Control and Professional Standards Review Organization (PSRO) efforts. To give an example of this difference in focus, consider a case in which the patient's need for nursing home care is at issue. The Utilization Review Committee or PSRO would question whether the particular nursing home stay was appropriate to that patient's health needs, while an investigation for abuse would focus on whether the provider showed a repeated pattern of utilizing inappropriate nursing home services and on whether this pattern of service increased the provider's financial gain.

A primary goal of the fraud and abuse control effort is to accurately determine the extent of provider fraud and abuse in the Medicaid

program. Although present assessment capacity is not based upon scientific measurement but rather relies upon observation and consultation with individuals in the field over an 8 month period, the estimate of the nationwide average rate of both fraud and abuse is a range between 8% and 15%. Most of the variation of this range is caused by the difficulty in defining abuse. However, it is essential to realize that the rate of fraud and abuse varies greatly among three categories of States. Type A States, defined as States which exert a tight management control over their programs, have rates between 1% and 4%. Type C States, defined as States with little or no management control over their programs, might have rates as high as 20% - 30%. Type B States, defined as States which have experienced high levels of fraud and abuse but have recognized the need for control and have begun to implement required control mechanisms, fall at various rates between 5% and 20%, depending upon the success of the corrective action.

The importance of the States' success in controlling provider fraud and abuse becomes clearer when the administrative structure of the Medicaid program is understood. Although Medicaid is a joint Federal-State effort, the primary responsibility for the control of fraud and abuse, as well as the administration of the Medicaid program itself, falls onto each individual State. This structure does not preclude the Federal government from pursuing the recovery of lost funds, or if appropriate, the prosecution of guilty providers. Primary State responsibility merely means that the Federal government will take action only when States fail to do so, or when it is determined necessary for proper administration of the Medicaid program.

For this reason, the Federal role to date has been primarily one of monitoring, technical assistance, and providing financial incentives to encourage States to develop effective management control systems. As noted earlier, States with effective systems of management control generally reflect low levels of provider fraud and abuse. Consequently, a major effort in the Medicaid program has been the encouragement for States to develop the MMIS. Considerable attention has also been given to improving the overall financial management of the program.

Other management initiatives have been developed in areas of Medicaid Eligibility and Utilization Control, and a joint effort is currently underway with the States to control the fraudulent and abusive practices related to these programs. All of these efforts must be taken together as a total management initiative on the part of the States to insure the integrity of the Medicaid program.

CURRENT STATUTORY REQUIREMENTS

Fraud is in all cases a matter of law. Its exact definition will depend upon the statutes of the jurisdiction in which it occured. Federal statutes that are relevant to Medicaid fraud prosecution include:

- Section 1909 of the Social Security Act which makes fraud under Title XIX a misdemeanor punishable by a fine of not more than $10,000 and imprisonment for not more than one year, or both;

- 18 U.S.C. 286 which makes it a crime to enter into an agreement, combination, or conspiracy to defraud the United States by obtaining or aiding to obtain the payment of a false claim;

- 18 U.S.C. 287 which makes it a crime to present a claim against the United States knowing it to be false;

- 18 U.S.C. 371 which makes it a crime for two or more persons to conspire to commit an offense against the United States or to defraud it in any manner or for any purpose;

- 18 U.S.C. 1001 which makes it a crime for any person in any matter within the jurisdiction of any Department of the United States to knowingly conceal a material fact, or make false statements or representations, or make or use any false writing or document knowing it to be false;

- 18 U.S.C. 1341 which makes it a crime for any person to use the Postal Service for purposes of executing or intending to execute any fraudulent scheme or artifice.

Proof of intent is required to obtain a conviction of fraud; the need to demonstrate intent is the element that makes successful fraud prosecution so difficult. Such proof often involves large masses of evidence that demonstrate that the accused repeated false acts again and again. This difficulty is coupled with the inherent complexity of health care reimbursement in general and Medicaid reimbursement in particular.

Under State law, the exact definition of fraud will vary depending on the State involved. However, at the State level, proof of intent is usually also required, as it is at the Federal level. Some States have enacted legislation modeled on Section 1909, which specifies

the illegal nature of Medicaid fraud. Also, as at the Federal level, other State statutes such as those relating to larceny and misrepresentation can be used to prosecute Medicaid fraud.

Legal tradition and the nature of the Medicaid program dictate that redress should first be sought in State and local courts and that Federal prosecution should occur only in exceptional cases or in cases in which the State has declined or neglected prosecution.

Program abuse extends over a wide spectrum of practices. It begins with cases of possible fraud in which intent cannot be proven and includes a variety of practices which violate the spirit and the letter of Title XIX laws and regulations. Program abuse diverts Title XIX funding from the provision of appropriate and necessary covered health care services to Medicaid recipients. The end of the program abuse spectrum abuts on issues involving the utilization of services (utilization control) and quality of care.

As the above narrative indicates, the successful enforcement of sanctions for fraudulent and abusive practices is difficult, especially from the Federal perspective. For this reason the Department is currently considering a proposal to set up a Federal Civil Money Penalty Program, which would enable the Federal government to pursue, on a civil basis, providers suspected of fraudulent and abusive practices. This would not foreclose either the State or the Federal government from pursuing criminal sanctions if appropriate. Such a program, however, would allow for recovery of wasted monies without the complex procedures currently faced in carrying out prosecutions.

HISTORICAL DEVELOPMENTS

The basic fraud regulations in force today were part of "Supplement D" under which Medicaid was operating during its early years. They have been added to from time to time, but retain the same basic core. These requirements were apparently based on Medicare guidelines and speak only to processes and methods which the State must have in place. They prescribe that each State Plan must provide for the establishment and maintenance of methods and systems for detecting, investigating and referring cases of suspected fraud (not abuse) to law enforcement officials and a basis for verifying services with recipients. In order for its State plan to be in compliance, the State must merely include a brief statement in its plan in which it agrees to have the required systems.

The guidelines (PRG-23) explaining the required systems and methods were published on October 6, 1972. These guidelines point out that fraud is defined by the laws of each State as well as by Federal law and direct the States to consult with their law enforcement agencies for advice in designing the required systems. Guidelines explaining the verification of services requirement have never been published.

When these requirements were published as interim and final regulations, a requirement was added that the State imprint certification statements either above the provider's (here called the claimant) signature on all claim forms or above the provider's endorsement on all payment checks.

In 1971, a regulation was added to require the States to report to SRS, by means of a double blind number, all cases of suspected fraud referred to law enforcement officials and their subsequent disposition. Since March 1974, NCSS forms 119.1 and 119.2 have been used to gather this information on a quarterly basis.

Public law 92-603, passed in 1972, added a specific criminal penalty for Medicaid fraud, required a 100% Explanation of Benefits as an integral part of the Medicaid Management Information System, and made certain Medicare terminations binding on State Medicaid programs. The regulations implementing these legislative changes specify that the States must notify all providers and recipients of Section 1909 (the criminal penalty), specify that the mailing of the 100% Explanation of Benefits is a requirement for the 75% matching awarded an operational MMIS system, and alert the States that Medicare terminations will be binding on them upon their notification by SRS.

Several shortcomings are probably clear from this summary of Medicaid's fraud regulations. They do not even mention program abuse. They speak entirely to process and method rather than to the outcomes to be expected of an effective surveillance effort. It would be entirely possible for a State to have complying processes and procedure manuals, to report promptly and accurately, to execute all the required warnings and notifications and to still have a completely or largely ineffective surveillance system and a high level of fraud and abuse.

By 1974, reports of widespread fraud and abuse had grown in both number and severity and MSA determined that provider fraud and abuse control should be addressed as a distinct problem. Eleven positions were allocated to the Fraud and Abuse Surveillance Branch, which was placed within the Division of Program Monitoring in the Central Office. An additonal 108 positons for the fraud and abuse effort were requested in the FY 1976 President's Budget. These positions have been authorized by the Congress and the total number of staff now allocated to the initiative is 119.

FRAUD AND ABUSE CONTROL

MSA has approached the problem of fraud and abuse control with several underlying assumptions, all of which continue to appear valid.

- The dollar loss caused by abuse is far greater than that caused by fraud.

- Most providers are honest and the majority of fraud and abuse is caused by a small but costly percentage of the providers participating in the program.

- Eighty percent of Medicaid reimbursement is paid to about 15% of providers, which means that high volume providers receive the bulk of Medicaid dollars. Therefore, even in the absence of proof that high volume providers commit proportionately greater amounts of fraud and abuse, it is nevertheless reasonable to concentrate resources on high volume providers since they account for such a large portion of Medicaid reimbursement. One should not infer that this concentration of resources includes a belief that all high volume providers are either fraudulent or abusive.

- The amount and characteristics of the fraud and abuse found in a State will vary depending on the characteristics of administration of the State's Medicaid program.

- A close and inverse relationship exists between the quality of Medicaid management and the amount of fraud and abuse allowed to occur by the State's management control system. MSA believes that effective and informed management will preclude the vast bulk of fraud and abuse, and that although poor management is not the sole cause of fraud and abuse, it provides the climate in which these undesirable practices thrive. Therefore, fraud and abuse can be prevented by improving State program management.

Since experience has served to validate these assumptions, MSA has continued to operate under them.

PROBLEMS AND IMPEDIMENTS

Reference has already been made to the complexity of Federal administration of the Medicaid program by virtue of the fact that there are 53 Medicaid jurisdictions, each with control of its own program. With such an administrative nightmare, Federal-State cooperation is

essential. Just as important, however, is the capability of the Federal government, as well as each State, to develop a program that can be administered, that is, one which is not fraught with the all-too-common bureaucratic red tape. Unfortunately, however, such capability on the part of both the States and the Department has not been demonstrated.

Two major problems which contribute to fraud and abuse have been mentioned in more detail earlier in connection with the discussion on program integrity. They are 1) the complex and numerous regulations associated with Medicaid, and 2) inadequate program management, particularly in the areas of claims processing and management reporting systems. Previously mentioned problems in identifying and prosecuting providers engaging in fraud and abuse only add to these difficulties.

CURRENT STATUS

Successful implementation of a Medicaid Fraud and Abuse Control Program will not occur overnight. In fact, due to the complexity of the Medicaid program, and the added management difficulties of a joint Federal-State effort, MSA has deemed it necessary to take a dual approach, both short-term and long-term, for the control of fraud and abuse.

The short term initiative, entitled the Five Point Program to Control Medicaid Fraud and Abuse, is designed for the next two years. Briefly, there are five elements to the program: 1) Management Initiatives, 2) Deterrence of Fraud, 3) Federal-State Joint Review Efforts, 4) Provider-Consumer Involvement, and 5) Federal Agency Coordination.

The Management Initiatives element focuses on that area previously discussed - speeding the implementation of MMIS. In addition, efforts are being made to develop a Model Fraud and Abuse Control Program, to encourage interstate information exchange of best practices, and to extend the use of audit techniques. All of these programs are directed toward the improvement of State management of Medicaid.

The Deterrence of Fraud element focuses on increased staffing of all those units concerned with fraud and abuse control. The HEW Office of Investigation staff has doubled to 70 positions, while MSA's own Fraud and Abuse Unit added 108 positions to its original 11. At the same time, States are encouraged and are responding by increasing their own investigative units.

The third element, Federal-State Joint Review, is the major thrust of the Five Point Program. A three week prototype review of seven providers in Massachusetts was completed in May. Beginning June 14, the first full review of a major Medicaid funded State began in that State. A team of approximately 18 Federal reviewers were scheduled to spend six to ten weeks in that State, reviewing up to 120 Medicaid providers with review guides designed to detect "potential abuse". The next full review will be in Ohio in August, and subsequent reviews of major States will be made throughout the next two years. The review is designed to identify providers who may be guilty of violative practices and to refer them to the State or HEW Office of Investigation, if necessary, for further review and possible administrative action or prosecution. Also, the State's management process will be reviewed and recommendation for corrective action will be made when appropriate. This effort will focus on the States with major Medicaid expenditure programs. Needless to say, Federal-State cooperation is a key element for success of this program.

In addition to the full reviews, MSA is considering various proposals from States to combat the fraud and abuse problem. For example, MSA will utilize six of its 108 positions for six months to hire audit personnel to work for the State of Colorado and conduct nursing home audits. Colorado does not have a big enough Medicaid expenditure to warrant a full review, but a small investment of funds with no lost staff time may generate valuable results. Also, the State of Wisconsin has applied for increased Federal matching funds for a State oriented strike force similar to that of the Federal program. Since the structure of the Medicaid program is oriented around State adminstration and enforcement, such initiative is encouraged, and this proposal is under serious consideration.

Provider-Consumer Involvement, the fourth element, is designed to promote better communication and understanding with the two groups most intimately involved with Medicaid. The Secretary of HEW, as well as other high-level Department officials, will meet with provider groups to educate them as to the nature and problems of the Medicaid program, and to encourge these groups to police themselves. Internal policing is believed to be one of the most effective means of controlling fraud and abuse. Similar meetings will be scheduled with consumer groups in order to promote an interest in reporting practices which are believed to be fraudulent or abusive.

Finally, the fifth element of the Five Point Program, Federal Agency Coordination, is designed to encourage HEW to coordinate investigative efforts and information exchange with the Department of Justice and the Internal Revenue Service. The Department of Justice will be directly involved in any Federal prosecution of Medicaid fraud, whereas

information accessible to the Internal Revenue Service regarding income paid to providers by the States is invaluable in detecting and proving abusive or fraudulent practices.

In addition to the formal Five Point Plan, other steps are being taken to coordinate the Medicaid program and make its administration and enforcement more efficient. A major obstacle to date has been the failure of the Social Security Administration and the Social and Rehabilitation Service to exchange information regarding providers who are under suspicion of fraudulent or abusive practices. Regulations have been written, however, which would allow for such exchange. The clearance of these regulations is expected shortly. MSA is also beginning to make contact with PSRO and related personnel, as well as coordinating internally the efforts of the Division of Fraud and Abuse Control with that of the Division of Utilization Control.

Successful implementation of the Five Point Program and other related efforts should lead directly into the long-term program. If successful, all States will have implemented MMIS for more effective claims processing. In addition, the foundation will have been laid for continued provider and consumer participation, and cooperation with the Department of Justice and the Internal Revenue Service. The major difference between the short and long term initiatives is that the State Abuse Review effort (the formal name for the team reviewing the States with major Medicaid expenditures) will no longer be in operation. At the end of the two year review effort, many of those positions now earmarked for the review teams will be reassigned to the Regions. The Regions will continue to provide technical assistance to the States, and will have the increased staff to better accommodate any requests. Those team positions not reassigned to the Regions will remain in the Central Office, also with the function of technical assistance. In summary, then, once the Five Point Program has run its course, it is hoped that States will have sufficient management tools in place, that cooperation is achieved with providers, consumers, and other agencies, and that the role of MSA will be one of technical assistance rather than active review and enforcement.

NECESSITY AND APPROPRIATENESS OF CARE

DEFINITION AND SCOPE

The Medicaid program seeks to assure that the care provided to its recipients is necessary and appropriate for their needs in a variety of ways. The mechanisms by which it does this include utilization reviews, utilization controls, medical and independent professional reviews, and professional standards review organizations (PSRO's).

CURRENT STATUTORY REQUIREMENTS

In the 1972 Amendments to the Social Security Act, Congress added Section 1903(g) to the Act which requires States to have a program for controlling the utilization of institutional services in order to receive full Federal matching funds under Medicaid. This program, called "utilization control" (UC), is intended to emphasize better State management of Medicaid. To do so, it specifies certain mechanisms for assuring the necessity and appropriateness of care.

The law provides for reduction of Federal Medicaid funds if a State does not have an effective UC program which includes:

a) a physician's certification and recertification every 60 days that inpatient care is necessary;

b) a physician's plan of care for each patient;

c) a program of utilization review which covers review of the necessity for admission and the necessity of continued stay;

d) a program of medical review by independent professional personnel of patients in skilled nursing facilities (SNF's), intermediate care facilities (ICF's), and mental hospitals.

Under the law, Federal matching is reduced by one-third of payments for inpatient services for Medicaid recipients after their stays in institutions exceed certain prescribed limits (60 days in a hospital, SNF, or ICF, and 90 days in a mental hospital during any fiscal year), unless the State Title XIX agency is able to make a showing, satisfactory to the Secretary, that it has in operation an effective program of control of utilization of services.

NECESSITY AND APPROPRIATENESS OF CARE

The law requires State Medicaid agencies to have methods for insuring that before payment is made for care these mechanisms for controlling medical necessity and appropriateness are in place and that the State has methods for assuring itself of this fact. Although the State must assure that control mechanisms are operating effectively, with the exception of the reviews by independent personnel, the State does not actually carry out the requirements. Some exceptions to this exist in those States which have developed their own systems for conducting utilization review and for which they have requested a waiver to use these systems for one or more types of institutional care (i.e., hospitals, mental hospitals, SNF's, ICF's).

HISTORICAL DEVELOPMENT AND CURRENT STATUS

On-site surveys conducted by the Department of Health, Education, and Welfare in the first half of FY 1975 found many deficiencies in State utilization control operations. These surveys assessed State performance against the statutory requirements in effect at that time. These included existing utilization review regulations and regulations covering medical review and independent professional review. Regulations covering the Section 1903(g) requirements of the law had not yet been promulgated. These regulations were published on November 29, 1974, to be effective July 1, 1975. Subsequently, in May of 1975, the American Medical Association filed suit against the Department to withdraw portions of the utilization review regulations covering concurrent review of hospital admissions. As a result of the court action, the Department agreed indefinitely to postpone the effective date of those portions of the utilization review regulations and to revise and publish, as a notice of proposed rule-making, regulations covering utilization review in hospitals. This notice was published on March 30, 1976, and will be revised for final publication after review and consideration of public comments.

As noted above, while UC regulations were in various stages of development, the Department because of the specific nature of the statutory language covering UC, put major emphasis on developing and conducting surveys to validate State adherence to Section 1903(g) and existing regulations. By the end of 1974, the first penalty survey was conducted. However, it was legally unsupportable because of evidence of regional bias that was found to have entered into the survey results. Also, the lack of legally specific regulations covering the period of the early survey and, to some extent, a lack of specificity in current regulations have further hampered survey activity. A new survey will be completed in September 1976. At the present time, MSA, along with the Office of General Counsel, is developing the survey

techniques that will be employed and is arranging for training of the survey staff. This survey will be geared only to specific statutory and regulatory bases. Thus far, the Department has focused on greater use of State quarterly showings as required by Section 1903(g) of the Social Security Act as a method for decreasing emphasis on Federal survey activity. Amendments to the legislation have been proposed which recommend to the Congress that the penalty amount be made more realistic and that some requirements be changed. Specifically, the penalty amount would be reduced to a small percentage of the Federal match for any level of care where the control system was found deficient. The present penalty amount of one-third of the Federal match for all long-stay institutional cases is so large that it could cripple a State program. Secondly, the certification and recertification requirements would be removed or modified to focus more on physician-patient interaction and away from a paper certification. The utilization review requirements were modified in late 1975 to eliminate review of each case and focus on screening and review of exceptional cases. This activity represents a beginning of the process of changing focus to emphasize better State management of Medicaid. Much activity will be required to completely refocus State and Federal involvement in assuring the necessity and appropriateness of care. Some of the issues that will be involved to accomplish such a change of direction are discussed in the following pages.

BROAD OBJECTIVES

The Federal government and States are in a unique position to assure that surgery, hospitalization, and other institutional care are kept to the minimum level compatible with adequate health care. Utilization control is one component of the necessary management and administrative techniques needed to manage the Medicaid program. MSA is starting to more actively emphasize this premise by recognizing that utilization or management controls are necessary in all aspects of the Medicaid program. Congress and SRS have basically said to the States, "Here are the minimal requirements necessary to properly manage the Medicaid program." But there is a need for a more concerted effort to provide the States with the tools and assistance necessary to properly manage the program.

PROBLEMS AND ISSUES

The Federal Role

Section 1903(g) of the 1972 Amendments to the Social Security Act placed

an affirmative responsibility on the States to assure that patients were placed properly in institutions. This section, effective July 1, 1973, requires each State to make a satisfactory showing to the Secretary, on a quarterly basis, that it has an effective program of control over the utilization of institutional services as described previously in this chapter. Further, the statute requires the Secretary to validate States' assertions of an effective program. When States are found not to have an effective UC program, penalty reductions of Federal Financial Participation are to be imposed.

Since the 1972 Amendments were enacted, substantial MSA staff time has been devoted to developing and conducting utilization control surveys to to validate State adherence to Section 1903(g) and accompanying regulations pursuant to the penalty provisions of that Section. If the States are found out of adherence with this section, a penalty must be applied.

By the end of 1974, two surveys had been conducted and, while these surveys provided considerable insight into State UC implementation, the application of 1903(g) penalties could not be legally supported. As noted earlier, this was due to certain technical difficulties in carrying out the survey.

MSA, along with the Office of General Counsel, has developed a new survey for examining State adherence to the UC requirements during FY 1975 to determine if penalties should be applied; the survey is to be completed in September of 1976. A great deal of staff time has been spent in designing a survey that will allow the application of penalties to States which had not performed the required utilization control. This effort, however, has been at the expense of assisting the States to fulfill their statutory requirements.

Section 1903(g) also requires the States to make a quarterly showing which must satisfactorily show the Secretary that the State has had in place for the previous quarter an effective program of control over the utilization of institutional services. To date, MSA has received as a showing a simple statement from the responsible agency head that, indeed, the State has in place an effective UC program. This has been a paper exercise at best.

It has proven difficult to determine what is an "effective" UC program much less to identify measures with which to determine "effectiveness". The whole concept of UC is still in its infancy and, as a result, most States efforts are generally in the experimental stage. There is no commonly accepted "best" method for implementing UC and no agreement on an acceptable set of objectives for the individual UC components. Although an interim showing has been prepared and field tested, a final

format will involve considerable work with the Office of General Counsel and other HEW policy units.

Lost, as a result of the above activities, have been efforts to positively support State implementation of UC efforts. There has been little, if any, time devoted to assessing existing State systems to identify innovative methods and procedures for controlling utilization or to providing feedback to and among States on their utilization control programs. Further, there has been no time to aid States in developing mechanisms with which to actually implement and/or improve the required controls. States are constantly reminded of the implications of possible penalty and quarterly showing decisions, but rarely are they provided any concrete instruction of assistance in capitalizing on the minimum procedures required in the statute and existing regulations. Further, attempts to design better surveys and develop meaningful quarterly showing reports have been hampered because DHEW staff have been unable to devote sufficient time to learning about State utilization control operational aspects.

The direction of the UC effort in SRS must be shifted to defining effective UC, looking at the results of the various control mechanisms, and also developing mechanisms and tools which can then be used to support the UC process including use of the Medicaid Management Information System as an information base. SRS should design a UC module that will track the processes, examine the outcomes and results of these processes, determine their impact on assuring that care is both necessary and appropriate, and share with States these findings.

The first step in this direction should be emphasis on quarterly showings which are designed and used to allow SRS to reasonably assess the UC process within any State. Such quarterly reports should be as useful to the head of the Single State Agency in evaluating the program for State management as it would be to SRS.

SRS must analyze in-depth the UC processes and their results and, based on this, determine which of the UC mechanisms are effective and which are in need of change.

Alternative Utilization Review Systems

Section 1903(i)(4) of the Social Security Act (effective July 1, 1973) provides that the Secretary may grant a waiver of the requirement of Section 1861(k) of the Act to States which demonstrate to his satisfaction that their systems are superior in effectiveness to those procedures required under Section 1861(k). Section 1861(k) prescribes the basic utilization review procedures which must be used for hospital

and skilled nursing care for Medicare. The statute requires Medicaid to use the same requirements. Currently, four States are operating under an approved waivered system involving reviews in the hospital level of care. These States are North Carolina, Illinois, Texas, and Massachusetts. The latter State, Massachusetts, is almost completely converted to PSRO review auspices. Two other States, Pennsylvania and California, are operating alternative UR systems, as permitted under MSA-73-18, but have not been formally approved. Delays in approving these States were due to regulation changes, State reorganization, and programmatic changes.

Seventeen States have requested a waiver for alternative systems for use in skilled nursing facilities; these States are Alabama, Arkansas, California, Connecticut, Georgia, Hawaii, Kentucky, Michigan, Missouri, Montana, New Mexico, North Dakota, Oklahoma, Ohio, New Jersey, Texas, and Washington. No waiver has been approved for this level of care. Insufficient documentation and programmatic uncertainties and changes resulted in an action transmittal which was sent to States on May 24, 1976. This transmittal stipulates the type of information required for review of each State's proposal for an alternative UR system and establishes August 31, 1976, as the deadline for providing such documentation. Thereafter, State requests are to be assessed and appropriate action taken.

It is particularly crucial to look at future plans for waivered systems in light of PSRO activity and current regulations. All hospital waiver requests involve concurrent review in one form or another; in addition, the State systems require admission review within one day of admission, thus providing tighter controls than the revised regulations published March 30, 1976. In essence, these alternative hospital review systems can be used as research projects, providing the Federal government data and information to use in promulgating future policies as well as in assessing the efficacy of present policies and regulations.

The issuance of waiver approvals for the hospital UR system and the consequent assessment and technical assistance provided to the States has highlighted one major weakness. Assessment and issuance was conducted in the Central Office (C.O.) by an Interagency Ad Hoc Committee made up of representatives from the Bureau of Quality Assurance, the Bureau of Health Insurance, and the Social and Rehabilitation Service. The review of each request was a paper review of submitted documents; no State was visited prior to approval. Documentation was channeled through the Regional Office (R.O.); technical assistance to the States from the C.O. was also channeled through the R.O. It is abundantly clear at this point that communication to the States via the R.O. was not adequate, partly stemming from the fact that centrally-made decisions and actions were not clearly understood by the R.O.

and partly due to the lack of attention to waivered systems from the R.O. Understaffed as R.O.'s are, other priority actions took precedent; consequently, States received little help in this area.

Given current C.O. priorities and staffing, the amount of time which will be devoted to waiver issuance for other levels of care will be less than that devoted to review of the hospital UR proposals. This presents two options which can be taken in acting upon the pending requests and in performing the upcoming evaluations of the systems initially granted waivers. These options are:

1) Identify more staff within the Department to review and assess the State systems and work with States on any areas of weakness; or

2) Evaluate the Systems strictly on documentation submitted involving minimal C.O. and R.O. staff time as currently available.

If the decision is to devote more time to the waivers, SRS can then act as an advocate for or against the alternative systems with the other agencies. Technical assistance can be provided by C.O. staff with follow-up by R.O. staff. This procedure will also facilitate our goal of developing these systems as research projects of national impact. Thus, although the on-site assessment will require more time initially by C.O. staff, the waivers requests will be expedited more efficiently and more thoroughly.

The alternative State systems can provide us with information not available under PSRO or Title XVIII systems. Inasmuch as PSRO activity is limited in the skilled nursing level of care, the State systems covering this level of care can provide both cost and quality control experience information which could be influential and helpful in determining future policies for PSRO or any other review system in long-term care.

Alternatively, if the decision is to assess the systems on the basis of documentation only, it can be assumed that several of the systems will be denied waivers and that this will result in strong opposition from some States.

In either case, there is a need to clearly specify and to carry out a long-term approach to these State review systems which will lead to either program improvement and differentiation for unique State conditions or phasing out to achieve national uniformity.

QUALITY OF CARE

DEFINITION AND SCOPE

Public concern for the quality of medical care purchased is increasing each year. This concern is evidenced to an even greater extent by the large purchasers of medical care: Medicaid, Medicare, Blue Cross, Blue Shield, etc. The primary questions are: What are we getting for our money? Was the service necessary? Was it provided properly, according to professional standards, and in the least expensive manner? What can be done to assure affirmative answers to the questions above? The institutional quest for these objectives is through some quality assurance scheme which focuses on the numerous components of quality to make certain that the essentials of each are present. Quality assurance in Medicaid may be viewed as an integral part of program integrity and/or program management.

In Medicaid, concern for assuring quality extends to all services and focuses in varying degrees on all the major dimensions of quality. The basic approach to quality in Medicaid has been in the area of capability standards. In the case of institutions, these vary from fire safety codes for the protection of life to availability of equipment and staff to assure professional medical capability. Such assurance of capability on the part of practitioners has been secured through licensure, i.e., certification by professional and/or legal bodies. These requirements do not assure that quality care is ultimately provided, but it assures that the technical/professional capability exists, where as the absence of such capability would most often preclude quality care.

More pertinent and vital aspects of quality are revealed through reviews of performance by institutions and practitioners while providing health care services. Unlike the capability dimension mentioned previously, the performance review has a limited basis in history. Tests of performance raise questions about the necessity for the service, the appropriateness of the care actually provided, and whether the least expensive mode of care was used. All these questions are highly subjective and judgemental. Only recently have criteria, norms, and standards been available to act as a basis for such decisions. Performance reviews are becoming an integral part of Medicaid service reviews.

Additional components of quality of care include quantitative adequacy of services provided, accessibility of health care resources, and consumers' perception of health and medical needs, including knowledge of how to use the delivery system. Medicaid has sought quality through requiring more comprehensive services and through making services more accessible through the provision of transportation. The more difficult program task of providing health education has been largely neglected.

HISTORICAL DEVELOPMENT AND CURRENT STATUTORY REQUIREMENTS

Since its inception, Medicaid program costs have increased substantially, partly as a result of the many more States coming into the program, the more than doubling of recipients, and the increases in the wages, prices, and fees paid to health care providers. While the program may be achieving results in providing greater access to health care for people who were precluded by their low income, the increase in the costs of the program has been a source of concern in both the State and Federal capitals. Considerable pressure has been introduced to gain control of these costs.

Almost from the beginning of the program, State Medicaid programs have tried measures to assure that only necessary and appropriate medical care was provided to eligible patients. These measures were introduced, of course, not only to save costs and prevent wasteful use of scarce medical care resources, but also to assure an acceptable quality of health care. "Unnecessary hospitalization and unnecessary surgery are not consistent with proper health care", to quote from the Senate Finance Committee Report.

The original law establishing the Medicaid program in 1965 made the first Federal reference to quality assurance in terms of specifying the need for both institutional and noninstitutional care, the idea being that in order to assure quality of care both practitioner services (such as physician care) and institutional services (such as hospital care) are needed.

The 1967 Amendments expanded the scope of covered services because it was believed that greater comprehensiveness was necessary to assure quality of care. The Amendments also introduced the notion of "utilization review"; although the law did not specify what it should be or how it should be done, it was important because it recognized the need for a "utilization review" function to assure quality of care.

Since 1968, State Medicaid programs have been required to operate systems of "utilization review" (UR) to safeguard against unnecessary utilization and to assure that payments were consistent with efficiency, economy, and quality of care. The techniques which States have used to meet this requirement and the degree of their success have been as varied as the other characteristics of Medicaid. Some States depend on their own State agency staffs to review claims and pay their bills; some transfer some or all of these tasks to fiscal agents or to foundations. Some depend on peer review to check services after they have been rendered or even after the services have been paid for; others evaluate services before they are reimbursed, while still others require authorizing services in advance of their being rendered. Some States

depend upon statistical norms such as the Certified Hospital Admission Program (CHAP) or Hospital Admission Surveillance Program (HASP); some operate through Experimental Medical Care Review Organizations (EMCRO's) or State Foundations for Medical Care. Some review all claims, others a selected sample, generally consisting of extremes and exceptions to the norms. While some instances of UR have been exemplary, the total effectiveness of these utilization review activities has been questioned, particularly by the Senate Finance Committee.

Regardless of the success or dimensions of its utilization review procedures, each program acknowledges the essentiality to the review process of the involvement of the physician, who is a major determinant and initiator of the services to be evaluated.

The history of Medicaid exhibits a rapid and intense expansion of requirements focusing on institutional capability. For the most part, these were directed at long-term care institutions. This effort has resulted in an appreciable upgrading of institutions' ability to perform.

The 1969 and 1972 Amendments again increased the requirements for institutional standards to further assure quality of care. These progressive requirements have substantially upgraded the quality of institutional facilites over the past several years, particularly those providing long-term care.

The 1972 Amendments also required that State Medicaid agencies institute "utilization control" procedures for all services paid for by Medicaid. In addition, Professional Standards Review Organizations (PSRO's) were authorized and given priority for reviewing institutional care in those areas where medical societies choose to establish them.

P.L. 92-603 contained several sections having a direct bearing on UR and quality of care in Medicaid. Section 207 authorized a one-third reduction in Federal matching for long-term stays in institutions if States fail to have effective programs of control over the utilization of institutional services or if they fail to control the independent professional audits of patients as required by law. Section 207 also stipulated that an effective program of UR should include evidence that in each case for which the State makes payment a physician has certified on admission, and subsequently verified during the stay, that the services provided are needed on an inpatient basis. The significance here is the implication that some mechanism must be established to monitor each individual hospital case on admission and on a continuing periodic basis. This section also requires the Secretary to conduct sample on-site surveys of institutions where Medicaid patients receive care.

Section 237 of P.L. 92-603 requires participating hospitals and skilled nursing facilities to have Title XIX and Title V cases reviewed by the same UR committee already reviewing Title XVIII cases, or if one does not exist, by a committee which meets those standards established under Title XVIII. This section also permits the Secretary to waive these requirements and to permit States to substitute alternative utilization review systems if it can be demonstrated that the alternative system is superior to the Title XVIII system.

Section 235 made additional funds available to States (90% Federal matching) for the design and installation of automated computer systems capable of supporting UR systems.

Section 249F created the PSRO, a bold move forward toward addressing some of the broad concerns which had arisen with respect to Titles V, XVIII, and XIX. A key factor of the PSRO legislation is that it transfers to PSRO's the authority to make final determinations of medical necessity and appropriateness for payment purposes from the Medicare intermediaries and the State Medicaid agencies. This binding review authority gives the program great potential effectiveness. Individual PSRO's are required to develop norms of care and treatment from the patterns of practice in their geographic area and to use such norms as an initial screening tool in the review system. Norms, criteria, and standards will be used by nonphysician reviewers to screen out cases which require review by peer practitioners.

Thus, Medicaid has several options for assuring quality of medical care performance in addition to numerous quality assurance methods applicable to standards for capability. These performance options are: (1) the State utilization control system, including utilization review, medical review, and independent professional review, (2) any potentially superior review system permitted because the Secretary has waived other methods, and (3) the PSRO review scheme.

BROAD OBJECTIVES

1. To assure that medical services provided to Medicaid recipients are of high quality. The operating definition of quality should be related to the current state-of-the-art for any given professional medical service.

2. To assure that Medicaid services are provided only when medically necessary, i.e., that the services are within the range of current and local standards for professional practice.

3. Since public funds are to be spent for Medicaid, the most efficient and effective expenditures should be only for services whose quality meets accepted professional standards.

4. Public expenditures should be made with such outcome expectations as rehabilitation to employment, improved capacity to care for self, reduction of pain, prolongation of life, etc.

5. Medicaid quality assurance methods should monitor and indicate any serious patterns deviating from normative practice.

6. Medicaid management should be vigilant in enforcing quality standards.

PROBLEMS AND ISSUES

PSRO's for Long-Term Care

Some experts in the long-term care field say that with strict enforcement of existing quality requirements for capability little more could be gained by even more demanding requirements. Additional thrusts toward quality must be secured through new emphasis on performance. To date, Federal guidance on performance review has been concentrated on acute hospital care. Essential elements of such assessment include admission certification, determination of medical necessity, continued stay review, medical care evaluation studies, and profile analyses. Some long-term care experts say that those elements used in hospital review may be almost useless when applied to long-term care (LTC). They state that the kinds of functions required under Medical Review (MR) and Independent Professional Review (IPR) are much more revealing and meaningful in assuring quality. As PSRO's assume responsibility for LTC review, the Secretary may relieve the State of certain review functions. The concept and organization of MR and IPR were major advances. Any transfer of organizational responsibility for LTC review which permitted neglecting the functions embraced in MR and IPR should be presented. These functions should continue and, if the State is relieved of this responsibility, then the PSRO should be expected to perform MR and IPR functions.

Evaluation of PSRO's

Since the statutory creation of PSRO's nearly four years ago, estimates of their operating costs have ever increased. Original estimates of $50 million a year have grown to $200 million by Department spokesmen; some outsiders regard these estimates as grossly understated. Such

amounts must be taken seriously in considering the value of the results. Improvements in quality of care are desirable, but the care previously provided was among the best on earth. How much improvement is needed? Is this approach the least expensive means of achieving our objective? We believe that an objective evaluation of PSRO's is urgently needed to guide the Department in establishing priorities in this area.

Comparison of PSRO-type review with that conducted by other organizations using different methods needs to be made. In Oklahoma and Texas, we may have an opportunity to collect information about review schemes which differ markedly from the typical PSRO. Likewise, areas of States having no PSRO reviews under State control may be compared with those conducted in the same State under PSRO control. Even in areas where the PSRO conducts reviews and where the State has a Medicaid Management Information System, every attempt should be made to determine if retrospective review of cases selected by an automated computer system compares favorably with the PSRO approach.

Duplication of Information Systems

Medicaid agencies are showing increased interest in adopting or improving their MMIS. The output reports from MMIS contain much of the same information as will be needed by PSRO profile development. MSA brought this matter to the attention of various levels within the Department. Early discussions of this duplication indicated that all parties understood the issues and consequences (i.e., enormously wasteful duplication of effort), but we are still on a course of action leading to this outcome. In brief, both PSRO and Medicaid agencies will be collecting from hospitals data essential to their respective needs, the uniform hospital discharge data set (UHDDS); both will code and create tapes of the same information. There is also the possibility that additional duplication may result from data systems created by the Cooperative Health Statistical Systems. High level Departmental attention is certainly required to prevent unfortunate consequences.

ELIGIBILITY

Chapter 2

DEFINITION AND SCOPE

The access to Medicaid-financed health care for twenty-five million low-income persons depends largely upon their meeting the very specific eligibility requirements set forth in Title XIX and related statutes.

Medicaid eligibility is one area of the program which has fallen victim to all of the vagaries of the conflicting objectives for which the program was created. To permit complete flexibility and responsiveness to State needs and/or preferences, fiscal capabilities and political pressures, Medicaid eligibility conditions have been permitted to vary erratically from State to State. Efficiency of Federal monitoring and equity in treatment of possible eligibles have consequently been sacrificed.

These problems are shared by the two major cash assistance program administered by the Department: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI), and to a lesser extent by the Food Stamp and Social Services program (Title XX). Medicaid eligibility goes beyond the intricacies of these programs, however, in that it has incorporated the complexities of the cash assistance programs and augmented them by incorporating the complexities of health insurance administration with respect to deductibles, cost-sharing and covered services.

CURRENT STATUTORY REQUIREMENTS

There are over thirty separate statutory provisions specifying Medicaid eligibility requirements:

Title XIX

Section 1901 - Enabling Clause
Section 1902(a)(3) - Fair Hearings
Section 1902(a)(5) - State Agency for Eligibility Determination
Section 1902(a)(7) - Safeguarding of Information
Section 1902(a)(8) - Timely Furnishing of Assistance
Section 1902(a)(10) - Mandatory and Optional Groups
Section 1902(a)(12) - Medical Determination of Blindness
Section 1902(a)(14) - Basic Cost-Sharing Provisions

Section 1902(a)(15) - Cost-Sharing Requirements for Aged Individuals
Section 1902(a)(16) - Residence Requirement
Section 1902(a)(17) - Financial Eligibility Standards
Section 1902(a)(19) - Protection of Applicant/Recipient Interests
Section 1902(a)(25) - Third Party Liability
Section 1902(a)(34) - Retroactive Coverage
Section 1902(a) - Title X Agency Provision
Section 1902(b) - Conditions Prohibited under Title XIX
Section 1902(e) - Continued Coverage for AFDC Families
Section 1902(f) - Option for Restricting Eligibility
Section 1903(f) - Establishment of Maximum Medically Needy Income Levels (MNIL)
Section 1905(a) - Exclusions from Coverage
Section 1905(a) - Essential Person
Section 1905(j) - Coverage of Supplementary Payment (SSP) Recipients
Section 1905(k) - Treatment of certain Mandatory SSP Recipients
Section 1909 - Fraud Provisions

P.L. 93-233

Section 13(c) - Medicaid Eligibility for Individuals Receiving Mandatory State Supplementary Payments

P.L. 93-66

Section 230 - Coverage of Essential Persons under Medicaid
Section 231 - Persons in Medical Institutions
Section 232 - Blind and Disabled Medically Indigent Persons

Other legislation (P.L. 92-603 as amended) extends permanent eligibility for individuals receiving OASDI benefits in August 1972 and whose eligibility for Medicaid would have been terminated due to the August 1972 20 percent increase in OASDI benefits.

The lack of specificity in the statutory provisions has resulted in the need for detailed regulations and policy interpretations for the guidance of States in administering their programs. The need for legislative amendments in this area has long been recognized; the debate is over the direction such restructuring should take, as discussed below.

BROAD OBJECTIVES

The designation of a primary objective in the Medicaid eligibility area is extremely difficult because of conflicting program priorites within the Department.

At the bureau level, the primary objective is to resolve the major pending policy issues and thereby improve technical assistance to the State Medicaid program eligibility operations. Because of the complexity of Medicaid eligibility issues and the nature of the SRS policy clearance process, it is not unusual for a written policy inquiry to require over a year for resolution and clearance. This situation adversely affects State agency staff who need to know definitively the policy options available to them before they can plan and implement major sections of their programs. In addition, the absence of Federal guidance can result in the loss of millions of Federal dollars to States, in as much as many policy decisions have a significant economic impact. For example, under the provision specifying coverage of "reasonable classifications of children under 21", a State which must await Federal approval or disapproval of a reasonable classification is faced with the decision of funding coverage for such a group with the threat of retroactive denial, or of not covering the group and having the group's medical care needs go unmet.

A parallel objective to improving Federal technical assistance to the States is the reform of the existing Medicaid eligibility criteria. This is a three-pronged effort which involves (a) simplification and clarification of existing regulations, (b) clarification and codification of current policies through publication of a Medicaid Eligibility Manual, and (c) preparation of legislative amendments which would remove inequities in the current program as well as simplify current requirements through standardization of criteria.

The SRS-level primary objective is to determine ineligibility rates through quality control of eligibility operations and to prepare corrective action plans for States. This effort is seen as a useful management tool for State administrators to curtail program costs for ineligible recipients.

HISTORY

Most of the Medicaid eligibility criteria stem from the eligibility criteria established for the AFDC cash assistance program which was enacted with the original Social Security Act in 1935. When the Medicaid program was enacted in 1965 several major provisions were added which were peculiar to Medicaid (the most major being coverage of the medically needy, i.e., non-cash assistance recipients). Medicaid eligibility criteria were seen as an integral part of the AFDC (and other cash assistance) programs. It was only in late 1973, following enactment of P.L. 92-603 which radically altered the eligibility criteria for both the adult cash assistance programs and Medicaid, that

the responsibility for Medicaid eligibility policy development and technical assistance was transferred from the agency administering cash assistance to the Medical Services Administration (MSA). Since late 1973, MSA has established a staff of six professionals with responsibility for eligibility policy evaluation and development (including the Medicaid Eligibility Manual, regulations, and policy issuances for the States) and technical assistance (including State eligibility review, workshops for Regional and State staffs, and resolution of compliance problems). In addition, this unit provides technical assistance to the SRS Quality Control program, coordinates policy development and resolution with the cash program agencies and provides legislative support to the Commissioner in developing Medicaid eligibility reform amendments.

PROBLEMS

A major problem is the inability of MSA to provide definitive policy guidance in response to State requests. This is due to the SRS policy clearance system which requires the clearance of any MSA-proposed policy by both the Office of Policy Control and the Office of General Counsel, and a number of other offices in the Office of the Administrator (e.g., the Associate Administrator for Management). Because each office may make revisions to the proposed policy, and there is no time period within which a given office must clear a document, it is not unusual for even a simple policy inquiry to require a year or more to receive clearance and be issued. Needless to say, such timing is useless for State agency staff who need decisions on a rapid turnaround basis because of the great impact such decisions have on the lives of recipients, and on State budgets.

An example of the breakdown in the SRS policy development process is the inability of SRS to develop a policy on transfer of property. As with many other criteria, limitations on property transfers made in order to qualify for Medicaid had been a State prerogative, but with implementation of SSI in January 1974, and standardization of cash assistance eligibility criteria for aged, blind and disabled individuals, policy questions were raised about whether States which otherwise utilized SSI eligibility criteria for Medicaid, could, in addition, impose a ban on transfer of property by Medicaid applicants. In addition, could States impose such requirements on AFDC-related Medicaid applicants but not on SSI-related Medicaid applicants? The problem was complicated by the fact that SSI did not prohibit transfer of property; thus a widow could transfer a $60,000 home to a son and apply for SSI (and thus Medicaid) the following day and meet the $1,500 resource limitation. This policy was and is opposed by many States which believe that resources available to the individual should be utilized for payment of medical care costs

prior to the State's assuming such costs under the Medicaid program. SRS has been unable to develop a policy in this area, despite prolonged discussion and pressures from State program agencies.

A second major problem is the inequity built into the Medicaid program. The general public is under the impression that low income is the only criteria for becoming eligible for Medicaid. This is, of course, untrue and creates difficulties for MSA staff who must explain to thousands of individuals each year why they cannot be eligible for Medicaid, despite low income and/or high medical bills.

Many low-income persons are ineligible for Medicaid because they do not belong to one of seven categories of eligible individuals:

- the aged (65 or over)
- the disabled
- the blind
- certain groups of persons under age 21 (generally those in foster care)
- families with dependent children (generally female-headed or, if unemployed, male-headed)
- individuals who were "grandfathered-in" to Medicaid coverage as of January 1974
- Vietnamese refugees with low incomes
- certain individuals who received OASDI benefit increases in August 1972

These categorical restrictions on Medicaid eligibility mean that two persons with identical incomes and medical bills may be treated differently depending upon conditions other than income or medical need, such as age, living arrangements and previous receipt of certain types of cash benefits.

The inequities in Medicaid eligibility criteria stem directly from the Title XIX statute. Thus, to rationalize the Medicaid eligibility criteria by removing the more arbitrary criteria would require legislative amendment.

A third major problem is the flexibility currently provided to States in establishing Medicaid eligibility criteria which results in

a considerable fluctuation in State standards. Thus, for example, only 32 States provide coverage to medically needy persons, 14 States provide coverage to children under 21 otherwise ineligible for AFDC payments, and only 25 States provide coverage to families of unemployed fathers. Even more complicating is the flexibility provided States in establishing financial eligibility criteria. It is significant that of the 53 State Medicaid programs only 5 States have financial eligibility standards at or above a $5,000 annual income level for a family of four.

More significantly, of the 53 States with Medicaid programs, 15 currently have financial eligibility standards below $4,000 for a family of four. Once again the variations in State Medicaid financial eligibility criteria are a direct result of options mandated under the Title XIX statutory provisions.

The significance of the low financial eligibility standards and of the arbitrary exclusion of certain low-income groups is that less than sixty percent of the national low-income population is covered under Medicaid.

A fourth major problem is that of ineligibility rates. Given the extreme complexity of Medicaid eligibility criteria and the absence of adequate technical assistance to State Medicaid agencies, it is not surprising that the error rate for Medicaid eligibility has been estimated to be twenty percent. As an attempt to control costs and to improve the credibility and integrity of the Medicaid program, SRS has undertaken a system of quality control (QC) of Medicaid eligibility. The goals of Medicaid QC are similar to those of AFDC-QC; however, expectations of State achievements are considerably lower for Medicaid eligibility and the probability of federally established numerical targets with penalties for noncompliance is still remote.

The progress made by States in implementing Medicaid QC has not been promising. Fully half of the States are behind schedule in selecting and reviewing case samples. This may be due to the inadequate lead time given States to staff up for the program and to conflicting priorities facing State staff. A major unresolved question is whether the Medicaid QC system will incorporate review of Medicaid eligibility determinations made by the Social Security Administration (SSA) (through administrative agreements with States).

CURRENT STATUS

Medicaid eligibility activities are focused in two major areas--policy development and technical assistance. Into the first category fall

activities in policy evaluation and resolution of issues, regulation development, eligibility manual development, and maintenance and preparation of major policy initiatives, including legislative amendments. In the techncial assistance area, considerable time is devoted to problem-solving in specific States, conducting State eligibility reviews and follow-up activities, responding to Congressional and other inquiries, providing liaison information to APA and SSI, providing information to SRS contractors and to SRS, OS, and the public concerning eligibility criteria and operations on a State-by-State basis, conducting eligibility workshops for Regional and State staff, and collecting and analyzing data on eligibility characteristics for each State. Similar processes are in operation in APA and SSA for the AFDC and SSI programs.

At the State level, the eligibility activities are concerned primarily with operations, but also with policy development in the sense that each State redefines Federal eligibility policies for its State staff. An added complexity is that the Medicaid program is administered by the Department of Health in many States, while the eligibility operations are delegated to the State Welfare agency. Additional complexity is added through the presence of SSA which may determine Medicaid eligibility of SSI recipients in a State or provide coded information to States on SSI eligibles which is utilized by States to determine Medicaid eligibility for SSI recipients. Thus, it is not unusual to have three different agencies responsible for eligibility determinations in a given State, or to have diffused responsibility for such determinations and maintenance of updated eligibility data.

ISSUES

There are four primary issues in the Medicaid eligibility area:

(1) Should reform of Medicaid eligibility criteria be a vehicle for improved management of the Medicaid program?

(2) Should current inequities in Medicaid eligibility criteria be removed?

(3) Should Medicaid eligibility criteria be separated from that of the SSI and AFDC programs?

(4) Should quality control activities be emphasized at the expense of technical assistance and policy development activities?

These issues are interrelated in that improved management of the Medicaid program will result from simplified eligibility criteria

which in turn will result from separation of Medicaid eligibility criteria from the AFDC and SSI criteria. Simplification of Medicaid criteria will also facilitate QC activities and transform that program into a more useful management tool for State and Federal staff.

The first two issues were discussed in the 1975 Forward Plan. In as much as the issues are still as valid as a year ago, they are being raised again.

The first issue is concerned with whether Medicaid program management could be improved by reforming eligibility criteria. Historically, the Legislative and Executive branches have attempted to improve the management of the Medicaid program by imposing requirements on the State agencies administering the Medicaid programs and on the providers who participate in the program. The potential for improving program management through reform of basic eligibility criteria has been virtually unexplored. The few program initiatives in the area of eligibility have been limited to the process of eligibility determinations--as in the early experience of simplified eligibility forms and the more recent SRS Medicaid QC program--instead of more fundamental program reforms.

The processes and policies relating to eligibility have been neglected since the inception of the program in 1965; basically, this lack of attention derived from the location of the Medicaid eligibility function with the cash program agencies. During the last three years, however, this situation has changed, as a result of a number of events:

1. The enactment of P.L. 92-603, 93-66 and 93-233 (Social Security Act Amendments), which established the SSI program and made major changes in Medicaid eligibility criteria and options.

2. The transfer of the Medicaid eligibility policy function from APA to MSA in 1972. The changes introduced by P.L. 92-603 made the separation of Medicaid eligibility policy from MSA no longer tenable.

3. The implementation of the SSI program by SSA, which established for the Medicaid program new eligibility criteria and processes for all aged, blind and disabled applicants.

4. The Congressional and Administrative interest in ineligibility rates for all public assistance programs, and the resulting establishment of quality control programs by SRS for the AFDC and Medicaid programs and by SSA for the SSI program.

As noted above, recent legislative amendments made major changes in the Medicaid eligibility criteria in the options available to States. The two most major changes may be summarized as follows:

- The eligibility requirements for SSI replaced those of the cash assistance programs for the aged, blind and disabled (Titles I, X, XIV, and XVI), and the States were permitted to provide coverage to certain groups of supplementary payment recipients.

- States were no longer required automatically to provide Medicaid coverage for all aged, blind and disabled cash assistance recipients but could, instead, retain their January 1972 standards or establish any other standard which was not more liberal than the SSI standard. If States opted not to cover all SSI recipients, they were required, however, to institute a spend-down similar to that in effect for the medically needy programs (regardless of whether or not they also had a medically needy program).

The policy questions raised by the changes in Medicaid eligibility are so complex that SRS policy on such changes in large part has not been finalized. Major policy issues remain "under review" almost three years after the enactment of P.L. 92-603. This absence of policy guidance is due to several factors:

1. The extreme complexity of the statutory Medicaid eligibility provisions.

2. The absence of specificity or Congressional intent for many of the above provisions.

3. The cumbersome SRS policy clearance system.

4. The requirement that Medicaid eligibility incorporate some but not all of the eligibility policies established for the cash assistance programs, which are administered by SSI and APA.

The absence of policy guidance has resulted in inadequate technical assistance provided to the Regional and State Medicaid eligibility staff and the failure to monitor State compliance with current Medicaid eligibility law. As a result, States are proceeding independently, without benefit of assurance that their eligibility practices and policies are in compliance. Most important, millions of individuals are being denied assistance or incorrectly being provided assistance.

The SRS Medicaid QC staff have estimated on the basis of preliminary tests that the ineligibility rate for Medicaid is 20 percent. This could mean that as many as five million individuals currently receiving Medicaid are not in fact eligible for such assistance.

Unfortunately, the SRS Medicaid QC program, while a valid program effort to determine problem areas in the administration of existing Medicaid eligibility policies, misses the larger issue of the need to reform the basic Medicaid eligibility criteria.

The need to reform such criteria is apparent by:

1. The length of time it has taken to develop Federal policy for the issues raised by P.L. 92-603 (e.g., States are still waiting for responses to policy queries raised in 1974);

2. The lack of understanding of the existing policies by the State agencies determining Medicaid eligibility (apparent from the review of 14 State eligibility operations in FY 1976); and

3. The inability of State agencies to administer many of the provisions they do understand (e.g., spend-down and the 133 1/3% limitation on establishment of MNIL's). In brief, the present Medicaid eligibility provisions are virtually unadministerable by all but the smallest States with the simplest Medicaid programs. Federal efforts to review such administration through the SRS-QC program will be frustrated by the complexity of the process itself.

Another unanticipated and undesirable side effect of the complex Medicaid eligibility criteria is the existence in most States of huge bureaucracies whose function is to manage the Medicaid and cash assistance eligibility determination processes. The increasing documentation and staff work performed for each case translates into higher administrative costs which divert program funds from the funding of medical services.

Establishment of simplified national Medicaid eligibility criteria would not only assure that Federal funds are being spent in an effective manner for the basic health care needs of the poverty population, but would facilitate State administration and Federal monitoring, in addition to reducing administrative costs.

The second issue is whether Medicaid eligibility criteria should be separated from that of the SSI and AFDC programs. As discussed above, Medicaid eligibility criteria have traditionally been tied to the criteria used in the AFDC and SSI cash assistance programs. Although the Medicaid criteria are considerably more complex than the criteria used for the SSI and AFDC programs (e.g., consideration must be given to such factors as the volume and timing of incurred medical expenses, the relationship to other health insurance programs,

the kinds of medical care benefits available to the recipient, and the timing of benefits)--the AFDC and SSI program eligibility criteria clearly dominate the Medicaid eligibility standards.

The fact that three separate bureaus are involved in policy development and interpretation for essentially one population group has created problems within the Department; these problems are augmented at the State level, where three separate State entities are coordinating with three separate Federal agencies.

The more significant issue is whether eligibility for cash assistance should be the primary criteria for need for medical assistance. In most States, applicants for AFDC or SSI cash benefits are automatically eligible for Medicaid regardless of their desire or need for medical services. The tying of Medicaid eligibility to welfare eligibility has meant that often the need for medical assistance is a less significant factor in determining whether an individual is eligible for Medicaid than the source of his income. Thus, because the welfare programs automatically disregarded significant portions of an individual's earned income (as a work incentive), an individual with earned income may be eligible for Medicaid while, e.g., a widow with lower total income comprised of OASDI benefits would not be eligible.

Furthermore, when major needed changes in the welfare programs are undertaken, their impact on Medicaid is frequently not anticipated and is often disastrous. For example, the federalization of the adult cash assistance programs required many complex defensive reactions by Congress and the States to protect the latter from anticipated increases in Medicaid rolls. Another example is that of the Social Security benefit increases and SSI benefit increases required by law. Although the intention of raising payment levels to keep pace with inflation is commendable, the practical result is that the small increase in income means termination of Medicaid eligibility benefits for individuals in States which do not raise their Medicaid financial eligibility levels correspondingly and which do not have spend-down programs.

The move away from welfare eligibility criteria has been evidenced in the enactment of the Title XX social services program. The use of financial criteria alone is seen as a more feasible and equitable approach in the provision of publicly-financed benefits for designated target groups.

There is considerable merit in the argument that while a single dollar of excess income can be a valid reason for denial of eligibility for cash assistance, such a factor should have no bearing on that individual's need for medical assistance. It is difficult to defend a program policy which can deny medical assistance to an individual with $180

a month income (which is too high for cash assistance and thus Medicaid) but $350 a month in medical bills.

On the basis of the above discussion, it is recommended that financial eligibility criteria be the sole determining criteria for Medicaid eligibility. Factors such as age, marital status, family status, and eligibility for cash assistance should not be considered. Establishment of minimum and maximum financial eligibility criteria, with a mandatory spend-down program, will assure that individuals in need of medical assistance will have access to such assistance.

The third major issue is concerned with what changes in regulations and statutes are desirable to correct some of the inequities of Medicaid eligibility, whether measures should be taken to correct Medicaid notches, whether steps should be taken to rectify inequities due to Sec. 209(b) options and whether national eligibility standards should be proposed. Since its inception, Medicaid has been a program of severe inequities, almost all of which have been mandated by law. Examples of these inequities include the following:

In States without medically needy programs, individuals and families with even one dollar of countable income in excess of the cash assistance standards are ineligible for any Medicaid assistance; in States with medically needy programs, individuals with considerable excess income may "spend-down" to establish Medicaid eligibility.

The tremendous variation in the financial eligibility criteria from State to State means that families and individuals with identical incomes, ages and disabilities are eligible or ineligible depending solely on their State of residence.

The statutory discrimination against male-headed families, single individuals and childless couples means that such groups are generally ineligible no matter how low their income, unless they can establish eligibility on the basis of disability, blindness, incapacity, or (in some States, under certain conditions) unemployment.

Because fewer than half of the States cover all children under 21 who are financially eligible, large numbers of needy children are being denied necessary medical care because they are in families in which both parents are present.

In 14 States, which provide a spend-down option only through Sec. 209(b) of P.L. 92-603, aged, blind and disabled individuals can spend-down to establish eligibility, but AFDC-related individuals in the State are denied Medicaid eligibility through the spend-down.

These are only a few of the program inequities which have been mandated by statute.

Some of the statutory inequities were introduced to establish national priorities for coverage (e.g., needy aged, disabled, or widows and orphans); the States have no control over these. There are numerous inequities which are created by the structure of the Medicaid program, which is to allow the States maximum flexibility to respond to their immediate budget conditions, by providing almost unlimited State options with respect to the groups covered, services provided and administrative methodology. While the principle of providing States with flexibility is desirable, the results of the States exercising their various options had led to questions about the policy and to severe criticisms of Medicaid.

The open-ended Federal match, for example, was intended to provide incentives for States to design and implement liberal Medicaid programs, yet fewer than one-third of the States have utilized one of the most crucial options available--that of providing coverage to all children under 21 who are financially eligible for medical assistance. The availability of unlimited Federal funds has not stimulated more than half of the States to set financial eligibility criteria at reasonably adequate levels nor to cover the medically needy or other optional groups. (In at least seventeen States, for example, less than one-third of the poor receive any Medicaid assistance.*) On the other hand, the availability of an unlimited Federal match has contributed to the establishment of very liberal Medicaid programs in the few States which have chosen to take advantage of the available Federal funds and whose tax base permitted extensive social service-related programs.

Virtually unlimited State options, combined with the absence of Congressional intent, have produced even more serious problems, relating to the extreme complexity of the Medicaid eligibility policy development process. The law and regulations are so complex that less than a hand-full of Federal employees are conversant with the issues and policies in effect. Because of the administrative problems created by the absence of Federal policies, a large number of States are ignoring Federal requirements and proceeding independently. In brief, the present eligibility system is <u>unadministerable</u>.

*Based on the ratio for 1970 of the number of Medicaid recipients in the State to the number of individuals in the poverty population in that State. Medicaid data from the National Center for Social Statistics; poverty population data from the Census of Population.

The imbalanced results produced by the Medicaid law have been a source of concern for many who view the present day Medicaid program as a severe distortion of Congressional, Administration and State intent. Even more alarming is the sizeable expenditure of public funds for a program which provides only sporadic or no assistance to millions of individuals and families who need basic health care. A rethinking of the purpose of Medicaid along with necessary statutory changes is indicated.

There are two basic options for addressing this issue. The first is to terminate statutory discrimination against male-headed families, single individuals and childless couples (and other traditional "categorical" links) by establishing national Medicaid eligibility standards varying only by financial eligibility criteria, which will continue to be determined by each State and to mandate a medically needy "spend-down" program for each State.

The basic justifications in the mid 1930's for limiting Medicaid assistance to the aged, blind, disabled and incapacitated are no longer as persuasive today when arguments for equity are compelling. The most recently established general assistance program (Food Stamps) has reflected the trend of utilizing financial criteria alone as the basis for eligibility. In addition, there is public sentiment to reverse the unforeseen adverse effects of the AFDC program on family stability. The national health insurance debate in recent years has demonstrated an acceptance of the principle that sex, marital, or parental status are not appropriate prerequisites to the right to health care and health care financing. Inclusion of the spend-down option (which utilizes the concept of maximum liability found in the Comprehensive Health Insurance Program and other major National Health Insurance (NHI) proposals), would assure that all individuals would have the benefit of medical assistance if their incurred medical costs were large enough. Finally, preserving the State option of determining financial eligibility criteria would assure that such criteria reflect local standards of living.

The primary disadvantage of this option is that it is only a halfway measure; State variation and inequities in respect to financial standards would still exist. Total reform of the Medicaid program requires establishment of nationally uniform financial eligibility criteria. The Medicaid experience has demonstrated that some States, if given virtually unlimited freedom in establishment of financial eligibility criteria, will not establish such criteria at a high enough level. On the other hand, as long as States must contribute to the cost of their Medicaid program, many will continue to establish lower financial eligibility levels because they are unable or unwilling to spend additional funds for Medicaid.

The second disadvantage of this option is that it would probably increase Medicaid costs considerably. While exact estimates are not available, the removal of the "categorical" requirements and the 209(b) option would probably increase Medicaid costs by about two billion dollars.

The second option is the same as the first with the addition of a national floor on the financial eligibility standards for Medicaid would be imposed. States would be free to continue establishing financial eligibility criteria at higher levels, but all criteria related to income (e.g., resources and income disregards) would be standardized. The States would be required to continue their FY 1976 financial efforts, with the Federal government assuming the increased costs.

This option has the same advantages as cited above for the first option. In addition, it has the advantages hoped for through the federalization of the adult categories under SSI, that of uniform national criteria at adequate minimal levels. It goes beyond SSI, to affect all population groups, not just the aged, blind and disabled.

The disadvantages of this option are that the increase in Federal costs could be considerable, depending upon the nationwide financial eligibility level chosen. Further, it would be inappropriate to undertake major reforms in Medicaid eligibility at this time, when NHI is imminent, and major efforts should be devoted to preparing and enacting it.

On the other hand, the increase in Federal costs would be more than outweighed by the programmatic advantages achieved by the changes. Furthermore, the experience of developing these proposals and of operating a Medicaid program with nationwide standards would be useful in the NHI debate.

Much of the increase in costs could be curtailed, by establishing, in addition to the nationwide minimum standards, nationwide maximum standards, for State eligibility. This move would not be inequitable, since all of the States would have spend-down programs.

The argument that such a major reform of Medicaid eligibility standards should not be attempted at this time because of the imminent enactment of a National Health Insurance law, may be countered by the considerations that:

(a) the implementation date of NHI will likely not be before 1979 or 1980;

(b) the reform of the Medicaid eligibility program cannot feasibly be tabled until such time because of the severe inequities and administrative problems which plague the program;

(c) the consideration and enactment of legislation amending the Medicaid eligibility laws will require less consideration by Congress than a major NHI bill and therefore can be enacted fairly quickly. Submission of legislative proposals for enactment by early 1977 could permit implementation by July 1, 1977;

(d) almost all major NHI bills have treated the low-income population separately for similar reasons: (1) they are generally unemployed or working at such low wages that health insurance from employers is unfeasible; (2) their health care must be subsidized by either State or Federal funds, or both, because of their inability to pay for such care. Therefore, consideration of a national program of health care financing for the low-income population is not only feasible, but practical inasmuch as a comprehensive NHI system could be built onto a national program for the low-income population. Reform of the eligibility standards can be the first step in establishing such a program.

The options presented are acknowledged oversimplifications of possible legislative reforms of Medicaid eligibility. They have been presented to provoke interest in the question, and to weaken the rigidity which is implied in the refusal to consider major legislative changes in Medicaid.

It is therefore recommended that the Department sponsor a discussion of legislative reforms of Medicaid eligibility. MSA will proceed to draft legislative options which embody Departmental objectives of simplifying Medicaid eligibility and of providing medical assistance to those now considered most in need of help.

The fourth issue is concerned with how the Medicaid eligibility quality control (QC) program should relate to the technical assistance and policy development functions and whether the Medicaid QC program is the preferred vehicle for reducing the error rate. As an effort which parallels the SRS AFDC-QC program, the SRS Medicaid-QC program was initiated on July 1, 1975. The objectives of the program are to reduce the estimated 20 percent ineligibility rate in Medicaid eligibility determinations and identify basic problem areas which will help States in improving their management of the Medicaid eligibility determination function.

Questions have been raised concerning the priority placed on the Medicaid-QC effort in relation to the other aspects of the Medicaid eligibility program area. These questions address two major problems:

1. Given the availability of 110 Medicaid eligibility staff to perform all policy development, technical assistance, and QC monitoring for the 53 State Medicaid programs, should 100 of these staff be devoted to the QC monitoring effort, as is presently the case? The argument has been made that the large number of unresolved policy issues, and the availability of the equivalent of only seven staff to respond to State problems nationwide, has produced a situation in which it is unrealistic to expect the States to have adequate Medicaid eligibility operations. This view supports the diversion of QC staff to the provision of technical assistance activities which would focus on State problem-solving.

2. The Medicaid-QC program is seen by some as a less than valid tool for the purpose of reducing errors in determinations of Medicaid eligibility. Unlike the AFDC-QC program, the Medicaid-QC program does not result in ineligible persons being removed from the rolls, but rather produces a figure suggesting the amount of erroneous expenditures expended for the ineligible recipients of the sample reviewed. (This is because the SRS ME-QC sample is drawn from the paid claims file.) The dollar figure for erroneous expenditures does not indicate the total dollar volume of misspent funds because only the claims pulled for the sample are used in tabulating misspent funds--no effort is made to determine how many times services were provided to the ineligible recipient and thus, the total dollar volume of misspent funds. Because providers have up to two years to submit claims for services provided, the individual whose eligibility is being reviewed may no longer be on the rolls by the time the paid claim is pulled for the sample and reviewed.

Secondly, the ME-QC program provides for a review of an individual's eligibility only against State but not Federal standards. Thus, a State could find an applicant ineligible by its own standards who could actually be eligible under Federal standards. Thus, the statistical results of the reviews are open to question.

3. The locus of the ME-QC program is in the SRS Office of the Administrator. This organizational setting has created problems for MSA, which has no control over the activities of the ME-QC staff. It is argued by some that a ME-QC program within the MSA organization would be more appropriate in that the policy and program framework for the ME-QC program is missing. For example, the ME-QC program is single-focused and has no interaction with the other major activities currently underway in this area within MSA (e.g., the simplification of eligibility regulations, the preparation of legislative amendments simplifying

Medicaid eligibility requirements, the provision of technical assistance to States on specific issues relating to QC, and the conduct of State eligibility reviews which more broadly evaluate State operations.

The priority, format and organizational locus of the ME-QC program should be considered in relation to the wider SRS dialogue on the SRS role in promoting improved State performance and compliance, and to the SRS-wide effort to simplify current regulations to provide States with greater flexibility in such areas as eligibility which are currently prone to errors because of their complexity.

In conclusion, MSA believes that major reforms of the current eligibility system must be made if significant improvements in the overall management of the program are to be made. MSA also believes that there are basic questions regarding equity in eligibility which should now be considered.

REIMBURSEMENT

CHAPTER 3

DEFINITION AND SCOPE

Reimbursement deals with the procedures and mechanisms by which Medicaid pays for the services received by its recipients. As a third-party payer, Medicaid reimburses participating providers directly for the covered services they render to Medicaid recipients; this is known as the vendor payment method of financing. This chapter deals with Medicaid reimbursement for inpatient hospital services, long-term care services, physician services, laboratory services, and prescribed drugs.

BROAD OBJECTIVES

The objectives of Medicaid's reimbursement policies are to assure adequate access to care, to pay for necessary and appropriate services on a reasonable charge or a reasonable cost basis, to assure the quality of care provided, and to contain the rising costs of the program.

INPATIENT HOSPITAL SERVICES

Historical Development, Current Statutory Requirements, and Current Activities

The original Medicaid law in 1965 contained no provisions concerning methods of reimbursement for any services. Thus, from the beginning of Medicaid on January 1, 1966, until July 1, 1967, the method of reimbursement for inpatient hospital services was discretionary with each State. The 1967 Amendments, however, instituted the requirement that payment for inpatient hospital services (only) must provide for the reasonable cost of such services (Section 1902(a)(13)(D)).

By July 1967, Medicare had long since developed its principles of reasonable cost reimbursement for such institutional services. The Secretary, in meeting the Medicaid legislative mandate for payment of reasonable costs, opted to require States to use Medicare's cost-reimbursement principles. Such principles require that each facility be reimbursed all necessary and proper costs in the provision of care for program recipients. The Medicare methodology is often characterized as a "cost-pass-through" system in which there is no incentive for hospitals to be cost-conscious in providing services or in planning for expansion.

By 1970, inflationary cost pressures stemming from the Department's decision were the cause of State and Congressional concern. A report by the staff of the Senate Finance Committee stated the following:

> "In their efforts to control the hospital segment of Medicaid costs, States have been confronted with a barrier erected by the Department of Health, Education, and Welfare, based upon the Department's interpretation of the provision concerning reimbursement of hospitals under Title 19 (Medicaid) of the Social Security Act.
>
> Under Title 19, States are required to reimburse hospitals on the basis of 'reasonable costs'. No further discussion of the requirement appears in the title. Under Title 18 (Medicare), where 'reasonable cost' payment to hospitals is mandated, there are extensive clarifying provisions as well as substantial discussion in the committee reports. Most important, however, is the fact that neither in the statute nor contemporaneous committee reports are any cross-references found requiring that hospital reimbursement under Title 19 be identical to that under Title 18.
>
> The staff believes that it was the intent of the Congress that, as with many other welfare requirements, States would be permitted to define "reasonable costs" within general guidelines established by the Secretary of Health, Education, and Welfare. The Medicare pattern of reimbursement, even its specific formula, could fall within those guidelines, but States would not be restricted to the Medicare formula. Latitude in defining those costs would be afforded each State and the State's definition would be subject to the approval of the Secretary. This understanding seems reasonable in view of the differences between Medicaid and Medicare in terms of the ages of the populations assisted, sources of financing, and primary administrative responsibility. As it is, States are theoretically not permitted to depart from the Medicare formula in paying hospitals under Medicaid. However, at least one State, Connecticut, has challenged the Department. Connecticut maintains that it now pays hospitals their full 'reasonable costs' and that it would cost the State $4 to $5 million more annually if they had to pay under the Medicare formula."
>
> (From Medicare and Medicaid: Report of the Staff to the Committee on Finance, U.S. Senate, February 9, 1970.)

In a 1970 meeting of State Governors with staff of the House Ways and Means Committee, the desire of States for more flexibility in deter-

mining methods of payment was made clear. Also in 1970, New York State passed legislation which resulted in a method of payment under which hospitals were grouped on a reasonable class basis and payment was limited to the lower of a hospital's costs or 110 percent of the group's average costs. In response to these concerns, Federal Medicaid regulations were amended to allow States alternatives to Medicare's method of payment for inpatient hospital services.

Remarkably, only four States, California, Colorado, Massachusetts, and New York, have used this provision to create incentive reimbursement systems for inpatient hospital services. This is not to say that control of hospital reimbursement does not exist outside of Medicaid. A number of States control hospital costs through the use of State health care cost commissions which review facility budgets and determine prospective rates hospitals may charge the public.

Alternative methods of reimbursement take two common forms: a formula mode and a budget review mode. The formula mode is exemplified by the system used in New York State. The New York system provides generally for the use of the Medicare reimbursement principles in determining allowable costs. Hospitals are grouped according to type, geographic area, size of facility, and ownership. Payments are made on a prospective basis with a ceiling on the total cost based on group averages. The ceiling includes a cost trend factor for projected cost escalation in the rate year. The New York plan also provides for minimum utilization factors for maternity, pediatric, and medical-surgical patient days.

The budget-review mode is exemplified by the system used in Colorado. The Colorado system provides for the use of the Medicare reimbursement principles in determining allowable costs. Payments are made on a prospective basis with no retroactive adjustment of rates to actual cost experience. Under this system, each hospital initially proposes a prospective rate based on its operating requirements for the current rate year. Proposed rates must be supported by the provider's certified audit of its base year costs.

Problems and Issues

Interestingly, both New York and Colorado have attempted recently to freeze payments at existing levels due to each State's lack of resources to keep pace with current hospital costs. That is to say, neither of the systems were able to hold down total expenditures, since neither had the necessary standards which would define what is a necessary admission and what is a reasonably priced product.

In the 1972 Amendments to the Social Security Act, Section 223 added a provision to control ceiling costs which could be recognized for in-patient hospital services. Under the provision's authority, Medicare established dollar limits on per diem costs which would be paid for room and board and general routine services supplied by hospitals. Somewhat similar to the New York State method, hospitals have been grouped by geographic area and size (number of beds) and cost limits established based on the 80th percentile plus 10 percent of the median.

Current proposed legislation in the Talmadge Bill would establish target rates to control unit costs. The legislation would create a system of reimbursement which combined elements of the formula method of New York State and the budget review method of Colorado. Other legislative proposals introduced by the Administration would limit annual increases in hospital costs to 107 percent of prior year's costs.

It is seen that such methods of reimbursement divorced from notions of product specification and standardization are essentially futile for controlling total expenditures. Further, providers can affect the utilization of services (i.e., deliver unnecessary services) to assure that income will not be reduced when the reimbursement per unit of service is cut. Medicaid utilization review requirements for in-patient hospital services have been the responsibility of either hospital-based committees of physicians or out-of-hospital review groups called professional standards review organizations (PSRO's). The effectiveness of hospital-based review committees has not been great. In the case of PSRO's, the elaboration of criteria to determine the relevance of a particular hospital admission is in development. Such definition of standards is an essential program goal.

There are several things which can be done to contain the costs of inpatient hospital care. Given the present paucity of methods to affect total expenditures, resources should be committed to support PSRO activities. Demonstration funds should be committed to efforts such as the experiment in South Carolina in which hospitals are committed to using cost-engineering services to reduce costs. A promising experiment is underway in Rhode Island where all hospitals have agreed to keep the aggregate of budgeted costs for all hospitals within a "maxicap" established by the State's health care cost commission. Thus, if one hospital chooses to expand a new service regardless of other community services, it must consider the peer pressure which will develop from other hospitals which have competing demands on the finite amount of money available. An experiment financed in Maryland which involves review of hospital charges by a State health care cost commission is also especially noteworthy. Elements of a hospital's operations are measured in terms of efficiency and cost by comparison to peer performance. Rewards for the efficient operators are in the

form of capital expansion allowances. Policy should be directed to moving such reimbursement methods from an experimental stage into operation as part of the State's Medicaid program. Further adoption by other States of such reimbursement methods should be encouraged by offers of technical assistance.

LONG-TERM CARE

Historical Development and Current Statutory Requirements

As previously mentioned, there were no statutory provisions concerning methods of reimbursement under Medicaid before 1967. The 1967 Amendments, however, specified that, for services other than inpatient hospital services, payment could not exceed "reasonable charges consistent with efficiency, economy, and quality of care" (Section 1902(a)(30)). In December 1972, Section 249 of P.L. 92-603 required that States must pay for institutional long-term care services, i.e., skilled nursing facility and intermediate care facility services, on a reasonable cost-related basis as of July 1, 1976. The stated intent is that reimbursement for long-term care services should support the quality of care that Medicaid patients are expected to need and receive. The regulations permit grouping of long-term care facilities on a class basis and allow reimbursement ceilings to be set based on average costs or on standard costs.

Problems and Issues

In an examination of nursing home cost reports in New York State by its Moreland Act Commission on Nursing Homes, it was found that unit costs among nursing homes varied four-fold with no consistent rationale for much of the variation. For example, in the case of costs of nursing salaries, the largest single cost component, the variation in per diem costs was $5.87 to $23.34 among 52 homes in the sample. Much of the variance was explained statistically on the basis of scale (total employee hours) and regional wage differences. However, no patient characteristics factor was significantly associated with nursing cost differences. The study concludes that, in place of such eccentric costs, efficient care standards should be established and reimbursement should be based on the cost-levels of identified efficient homes meeting such standards.

Another problem which exists exclusively with regard to payment for nursing home services stems from the fact that the industry is composed predominently of proprietary homes operated on a for-profit basis. The problem has to do with sale and resale of nursing homes at inflated prices. That is to say, there is an incentive to sell the home at a point where maximum tax shelter benefits have been realized from any

accelerated forms of depreciation permitted by the Internal Revenue Tax Code. The new owner is willing to pay an inflated price for the property so long as he expects such price to be recognized as the adjusted historical cost for purposes of reimbursement for depreciation expenses than the original historical cost of a facility. "The resulting increases in costs do nothing to increase the quality or quantity of care available at the facility. With limited entry into the industry, with the State itself the dominant purchaser of services, and with the limited use of nursing home facilities for use other than as a nursing home, it becomes clear that the value of nursing home real property, at any time and within very broad limits, depends directly on the anticipated level of its future Medicaid reimbursement payments" (Reimbursement of Nursing Home Property Costs, New York State Moreland Act Commission, January 1976).

The New York State Moreland Act Commission recommends that, for all proprietary homes, existing as well as newly contructed,:

1. "Rental" amounts should be established as part of a per diem Medicaid rate. These amounts should be based on historical project costs of the homes (or on the adjusted book values now used by the Department for determining reimbursement rates) and be sufficient to provide a competitive rate of return on equity capital invested in property, assuming that the property is financed in a reasonably efficient manner.

2. No change in rental amount should result solely from changes in ownership within the proprietary secter, changes in financing, or the like.

Recommendations of the Moreland Commission concerning standard costs and valuation of property should be widely distributed to all States for consideration as a method of cost-related reimbursement which would counter present patterns of uncontrolled cost inflation.

PHYSICIAN SERVICES

Current Statutory Requirements

In conformity with the Federal statute (Section 1903(i)(1) of the Social Security Act), Medicaid regulations specify that physicians' charges recognized may not exceed payments which would be made under the methods of determining reasonable charges in effect under Medicare. Within such upper limits, States are free to specify the method and the amount of payment.

Problems and Issues

Most physician care is delivered on a fee-for-service basis. The prime control used by a few States to offset the incidence of services is to keep payments low (i.e., only recognize half of billed charges). In a more balanced attempt to cope with the problem of utilization control of physician services, the 1972 Amendments to the Social Security Act gave a legislative boost to physician group practices called Health Maintenance Organizations (HMO's). HMO's illustrate the concept of an arrangement for the purchase of services which limits total expenditures while providing for whatever patient care is necessary. Under such arrangements, payments are made on a per capita basis. The fixed sum removes any tendency for overdelivery of services or overelaboration of services delivered.

It should be noted that Title XVIII's method of reimbursement is based on payment of usual and customary charges; these are defined as the median of a charge for a given service derived from claims processed during the calendar year preceding the fiscal year in which the determination is made. In a report of the staff of the Senate Finance Committee (Medicare and Medicaid: Report of the Staff to the Committee on Finance, U.S. Senate, February 9, 1970, p. 59), the staff contends that the original intent of the Title XVIII language regarding the determination of "reasonable charges" was that customary and prevailing charges would only be one element in determining reasonable charges. It was expected that no charge would be considered reasonable which exceeded the amounts which Blue Shield was paying for its own subscribers. The report notes that, prior to Medicare, virtually all Blue Shield plans and insurance companies made payments on the basis of fee schedules rather than customary and prevailing charges. The report also notes that the committee report on the original Medicare legislation anticipated that such fee schedules (i.e., "a fixed and static basis for payment") would be used by Medicare.

Medicare's methods for reimbursement of teaching-physician services (i.e., in a hospital-setting) have been examined recently in a report issued by the Institute of Medicine, National Academy of Sciences. The report recommends that payment for such services, at the option of the providers, should be on a fee-for-service basis, on a reasonable cost basis, or, in the case of services delivered by a unified team of physicians, on a unified fee-for-service basis (which could be a per capita amount).

Current legislation proposed in the Talmadge Bill would require that Medicaid payments for physicians' services be at least 80 percent of the reasonable charge recognized under Medicare (Section 23). The provisions' stated purpose is "to assure continued availability of medical services

to Medicaid recipients and to ease the movement of patients from doctors' offices (because of artificially low Medicaid payments to physicians in some States) to high-cost hospital outpatient departments." There is some validity in the statement. In New York, the fee for office visits to physicians was $5 per visit in October 1974. It was claimed by New York City health officials that only 10% of physicians in New York City participated in Medicaid and, thus, pressure was put on the hospitals to provide ambulatory care. However, it is moot whether increasing fees for physicans' services will assure a greater supply of physicians in ghetto areas. Surveys of ambulatory care patterns in Alabama, Colorado, Maine, and Washington indicate that the use of outpatient services differs markedly by race.

Until such time as there is more success in defining what constitutes effective medical care, Federal reimbursement requirements should continue to permit States flexibility in determining schedules of payment. An effective limit on the unlimited capacity of health care providers to provide "more" services has been the fees which States are willing to recognize for such services.

At the same time, the Department should consider adoption of the following proposals from the Senate Finance Committee's staff report in 1970 (Medicare and Medicaid, February 9, 1970):

"1. An advisory board of actuaries and underwriters would be selected by the Secretary of Health, Education, and Welfare from private health insurance companies to assist in developing a schedule of fixed indemnity allowance for surgical and medical care for each of the nine Census regions in the nation (in recognition of geographic variation in charges for similar medical services). The allowances for any given region should not be more than 10 (or possibly 15) percent greater than the average for all other Census regions combined. Appropriate provision should also be made so that prepaid group practice and similar programs can provide care and be reimbursed on other than a fee-for-service basis.

2. The advisers would recommend specific maximum amounts allowable for covered services based upon a total monthly premium of $8 per beneficiary--the amount now paid-after allocating a sufficient portion of the premium for reserves and administrative costs.

3. The $50 deductible now in Part B of Medicare would apply only to charges for services rendered by nonparticipating physicians.

4. Payments would be made on the basis of 80 percent of the maximum amount allowable specified in the benefits schedule or 80 percent of the actual charge, whichever is less.

5. A participating physician would be one who agrees to accept up to the scheduled allowance as his full charge for the services he renders to all Medicare beneficiaries. In the case of a participating physician, payments would be made directly to him by Medicare. He would collect 20 percent of the schedule amount from the beneficiary. Alternatively, a copayment approach might be employed. For example, the beneficiary could pay out-of-pocket the first $2 or $3 of the charge for home and office visits.

6. Where a doctor did not elect to become a participating physician, all payment due from Medicare to beneficiaries for services rendered by him would be made directly to those beneficiaries on the basis of a receipted or non-receipted bill.

7. A physician could, upon appropriate notice, elect or withdraw from status as a participating physician.

8. The $8 monthly premium rate would be fixed by law and could not be changed except by legislative action.

9. In case the premium and reserves were inadequate to fully meet the obligations of the program in a given year, the advisory board would be expected to adjust the scheduled allowances downward so as to make up the deficit in the following year or years. Such revisions could be made applicable only to those regions experiencing abnormal utilization or could be made applicable nationally.

We believe this method of reimbursement offers the following advantages:

1. Simplified administration and reduced administrative costs.

2. Anti-inflationary structure.

3. Self-adjusting to the funds available.

4. Predictability of allowances and payments.

5. Strong parallel to and relationship to basic medical-surgical insurance policies now sold by private health insurers.

6. Avoidance of Federal determination as to whether a physicians' charges are reasonable.

7. Functions within the traditional framework of the medical insurance obligation of an insurer (social security) to the insured (beneficiary) whereby specified indemnities are payable to the insured by the insurer when he has incurred a legal obligation to pay a physician who has rendered care covered under the policy. The obligation to pay here, as with all private health insurance, flows from the insurer to the insured (and not from the insurer to the physician or other provider).

8. Beneficiary understanding enhanced and $50 deductible eliminated where services are provided by participating physicians.

9. Physician has freedom of choice whether to become a participating physician. That choice may be changed upon reasonable notice.

10. The Government will not tell the nonparticipating doctor how much to bill the Medicare beneficiary and it will not interfere with his privilege of collecting his own bills. The Government would pay its scheduled allowances to the beneficiary directly on the basis of a receipted or nonreceipted bill for covered services. That would fulfill Medicare's financial obligation as insurer to the beneficiary. The question of what the patient does with the money after he has been paid by Medicare would not be subject to governmental intervention and would remain a private aspect of the doctor-patient relationship.

To avoid fragmentation of fees, the staff recommends that uniform definitions of medical procedures and services be applied to the payment of benefits under Part B of Medicare.

> Adoption of uniform definitions would avoid situations such as that where a surgeon charges one fee for the actual surgery and then charges additional separate fees for normal preoperative and postoperative visits. Most Blue Shield plans allow a single inclusive fee covering the preoperative and postoperative care ordinarily and routinely provided in conjunction with the surgery itself. Appropriate definitions can be obtained from Blue Shield and others."

It can be seen that the proposal would limit total expenditures each year. The requirements for actuarial determination of payment allowances could complement PSRO analysis of utilization rates.

LABORATORY SERVICES

Current Statutory Requirements

Under Medicaid regulations (45 CFR 250.30(b)(3)(i)(B)), payments for laboratory services may be made up to a ceiling established on the basis of "prevailing charges in the locality for comparable services under comparable circumstances".

Problems and Issues

Aside from issues of quality of services (which are throughly documented in Congressional hearings conducted on the Clinical Laboratories Improvement Act of 1975), investigations of the clinical laboratory industry have uncovered practices such as the following:

1. Physicians purchasing controlling interests in clinical laboratories and then referring work to that laboratory;

2. Laboratories "renting" space at highly excessive rents in sites owned by physicians;

3. Laboratories supplying physicians with free equipment, personnel, and billing services;

4. Laboratories billing for a panel of tests performed simultaneously on one machine (sequential multiple analysis) as if each were a bench test (nonmechanized test) performed separately;

5. Laboratories paying consultant fees to "salesmen" for brokering Medicaid business to the laboratory;

6. Payment of fees in excess of the lowest costs at which tests can be obtained from laboratories using automated equipment; and

7. Payment of fees to physicians based on their customary charges for drawing specimens which are in excess of reasonable costs for such services.

At least one State, New Jersey, has attempted to preclude such practices, seemingly endemic to the industry, by setting conditions for payment to assure that amounts paid for services are reasonable. However, in response to the limits on prices paid, an increase in the volume of services provided could occur, so that total expenditures for such services would not be affected significantly.

A more effective solution has been proposed by Medicaid officials of the New York City Department of Health. The proposal combines controls over both payment for services and standardization of services delivered. One laboratory in each of the city's five boroughs would be given exclusive rights (on the basis of competitive bids) to process all Medicaid laboratory tests amenable to large-scale automated processing. Payment would be a combination of a maximum aggregate fee and a unit price for each test. Quality assurance provisions would include a "blind specimen" surveillance program, patient profiles, and physician profiles. The latter profiles would contain summaries of tests ordered by category and of tests found to be abnormal. The data would be used by Medicaid officials for utilization review and by participating physicians for purposes of self-assessment. The proposal represents a satisfactory arrangement for delivery of a service in that payment is tied to standard units of service. The value of the arrangement can be better appreciated in light of facts such as the following: program costs for independent clinical laboratory services (i.e., nonhospital based) in New York City went from $3.7 million in 1970 to $14.2 million in 1975; during the five-year period, the Medicaid population remained essentially static, reimbursement rates for laboratory tests remained frozen at constant level, and less than 40 new tests were added to the Medicaid benefit schedule. Aside from the projected cost savings (for the entire city of New York, the maximum aggregate bid was $5.7 million dollars), the proposal represents a step away from episodic, symptom-oriented care in which very little attention is paid to preventive health maintanance. The arrangement would get at the wasteful use laboratory services (some researchers have found that only five percent of the laboratory tests ordered on a medical service had a direct relationship to the management of a patient's clinical problems).

New York's proposal for reimbursment of independent clinical laboratory services illustrates the need to combine controls over both the price

paid for a unit of service and quality specifications. However, the proposal conflicts with Section 1902(a)(23) of the Social Security Act which requires that recipients be permitted freedom of choice in obtaining medical care. The provision has been interpreted to preclude New York City from requiring that all clinical laboratory services be sent to selected laboratories. To remedy the matter, Congressman Scheuer has introduced H.R. 12611 to amend Section 1902(a)(23) to exclude laboratory services from the freedom of choice provision. The Department should support the proposed legislation.

PRESCRIBED DRUGS

Problems and Issues

The so-called MAC (Maximum Allowable Cost) drug regulations became effective August 26, 1976. The use of estimated acquisition cost instead of average wholesale price will result in some cost savings. The establishment of a maximum allowable cost for selected multiple source drugs will result in savings, but they will not be significant for several years. The selection and clearance for bioequivalency of a sizeable number of drug items will be a lengthy process. The future expiration of patients, however, makes the potential impact tremendous.

Payments for drugs under Medicaid increased from $706,746,000 in FY 1974 to $816,453,000 in FY 1975. In the first quarter of FY 1976, drug expenditures were 18 percent above the corresponding quarter of the previous year. Some of the increase was due to an increase in the number of recipients, but some results were from increased utilization.

The avenue which we should use to achieve further cost savings is drug utilization review in its broadest sense. This would include greater use of automated systems to produce data for retrospective review, provider education on prescribing, use of formularies, patient education on use of prescribed drugs, cost sharing, more use of patient profiles, and active drug committees.

A 'PRUDENT BUYER' STRATEGY

From FY 1971 to FY 1975, Medicaid payments for institutional care (inpatient hospital, skilled nursing, and intermediate care facility services) rose from $3.9 billion to $8.6 billion per year, an increase of over 120%. In FY 1976, expenditures under Medicaid for institutional care represented 69.6% of total Medicaid expenditures and are expected to consume an increasing portion of the Medicaid budget in the years to come. From

FY 1976 to FY 1982, these costs are currently projected to rise from $10.5 billion to $22.2 billion per year, an increase of 113%.

Presently, Medicaid recipients are free to choose whatever institutional facilities they wish as long as the facilities are certified by their State and agree to accept Medicaid as payment for care. Medicaid then retrospectively reimburses the facility on a "reasonable cost" basis. Within Federal guidelines, States have the option of establishing alternative reimbursement mechanisms if they so choose.

Medicaid presently allows both providers and recipients to "pass through" virtually all costs for institutional care which they incur which can be deemed "reasonable". There are thus no real incentives either for providers to constrain the costs of services they render or for recipients to limit the costs of services they receive. The consequence has been that both providers and recipients frequently utilize or obtain the costliest forms or packages of institutional services that are available for a particular treatment or procedure. Hospitals, for example, compete to install and use the latest, most sophisticated forms of medical technology, which attract both practitioners and patients, with the knowledge that the increased expense will, to a large degree, be picked up by third-party payers, such as Medicaid. These third-party payers, however, can no longer afford to underwrite the cost of continued intensification of service technology for standard and routine medical procedures and other institutional care. It is necessary to begin to shift the pattern of service utilization of recipients away from complex, expensive modes of institutional care to simpler, more economical modes having the same basic levels of effectiveness.

One of the most promising approaches is the establishment of systems which prospectively determine rates of reimbursement for institutional care. Under Section 222(a) of P.L. 92-603, the Department is experimenting with such prospective reimbursement systems. Preliminary analysis indicates that such an approach does restrain cost increases, but it is still too early to determine which of the variations is most cost-effective and to assess long-term consequences. To date, only four States (California, Colorado, Massachusetts, and New York) have attempted prospective reimbursement systems for their Medicaid programs.

An additional means of shifting patterns of utilization and holding down the rising costs of institutional care would be the adoption of a "prudent buyer" strategy for the purchase of such care. Such a strategy would build upon a system of prospective reimbursement. Since Medicaid is such a large volume purchaser of institutional care, it should be able to use this advantage to obtain for its recipients institutional care of acceptable quality at the lowest possible price. As a "prudent buyer", Medicaid could seek to define standardized "products" of institutional care for the

most commonly utilized types of services and procedures and to prospectively set the rates at which it would reimburse providers for such care. Medicaid recipients would then be induced to utilize those institutional facilities which would provide the needed services or procedures for the established prices. Such an approach would stimulate competition among facilities; those providers who would or could not meet the established prices would lose Medicaid revenues. It would be important for such systems to assure adequate access to needed institutional care within geographic areas, but at the same time inhibit the utilization of the most expensive forms of such care. The systems should be designed to be administratively efficient so that elaborate bureaucratic procedures or inordinate amounts of manpower would not be required to administer them. They should also be flexible enough to take into account varying circumstances, but only where adequate alternatives are not possible. As such a "prudent buyer", Medicaid would be able to maximize the efficient use and purchasing power of its dollars.

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM

CHAPTER 4

SCOPE, DEFINITION, AND STATUTORY REQUIREMENTS

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a major component of Medicaid. It was authorized by the Social Security Amendments of 1967, effective July 1, 1969. DHEW published final program regulations in November 1971. Congress mandated a one per cent penalty against Title IV-A (Aid to Families with Dependent Children--AFDC) funds on States failing to implement the program, effective July 1, 1974.

EPSDT is a preventive health program aimed at Medicaid-eligible individuals under the age of 21, which has the legislative mandate to "ascertain their physical or mental defects" (usually by a health screening) and to provide the health care or treatment needed to "correct or ameliorate defects and chronic conditions discovered . . ." by the screening process. Departmental regulations further require States to provide treatment for vision, hearing, and dental defects regardless of other State plan coverages. Finally, the penalty provision adds a third major program ingredient by requiring that States perform active outreach by informing eligible families of program benefits and providing or arranging for screening and treatment services. EPSDT, then, consists of preventive health screening, diagnosis and treatment, and outreach and management responsibilities.

BROAD OBJECTIVES

The objectives of the EPSDT program are complex, but the clear overriding need is to improve the health status of poor children. Many of the health problems of poor children are preventable, particularly the vision, hearing, and dental areas which are especially important for children. The expectation of need reflected five years ago in program regulations is being borne out by program findings to date; most referred conditions are in these three areas. Had only the preventive or screening dimension been added to Medicaid as the basis for EPSDT, many of the treatable conditions would not have been covered by State plans and the purpose of the program frustrated.

The objectives of the EPSDT program can be viewed from a variety of perspectives. Under a strictly process approach, the objective of the

Federal government is to ensure that each State and territory implements a functioning EPSDT program, as defined by each jurisdiction in light of the Federal-State nature of the Medicaid program. This is the general mission of the MSA EPSDT Division.

A more substantive approach would yield objectives such as:

- o to provide a wide range of preventive and curative health services to Medicaid-eligible children,
- o to reduce disabling and chronic conditions in the target population,
- o to improve, by prevention or early detection and treatment, morbidity patterns among Medicaid eligible children.

A final approach would identify desirable by-products or beneficial consequences of the EPSDT operation, although involving programs and policies far beyond EPSDT. Examples of these might be:

- o to change the utilization patterns of health care resources by Medicaid-eligible families from crisis-only care to less costly and more effective health maintenance encounters,
- o to reduce the costs of health care for certain kinds of conditions,
- o to help break the poverty cycle,
- o to improve the health care delivery system as it relates to Medicaid-eligible children.

Ultimately, the EPSDT program will be assessed in terms of its achievement of the substantive objectives. This can only be done, however, when the program is operating at a level of intensity and scope that could reasonably be expected to have impact on, for example, morbidity patterns of a large part of the U.S. population.

The EPSDT program is not yet a mature, functioning reality in a sufficient number of States to warrant Federal-level objectives such as reducing morbidity by some predefined percentage. It is a program still being implemented, with many ragged edges of uneven development across the States and across major program elements. At this point, then, objectives for EPSDT must center around the removal or reduction of barriers which impede States and the Federal government from implementing a functioning program in each State.

Many elements of a functioning EPSDT program already exist in a

number of States and primarily need to be tied together; other elements, such as those below, will have to be developed.

- o An extensive knowledge and effective use of all available health resources with an emphasis on primary care resources.
- o Aggressive outreach and casefinding designed to reach most of the Medicaid-eligible population under 21 (demonstration projects suggest that 80% of this population can be reached).
- o Detailed and effective health education to each recipient at least when eligiblity is determined and redetermined.
- o A health profile with the emphasis on prevention for each Medicaid-eligible under 21.
- o Case management (tracking) systems which will enable notification of eligibles on a periodic schedule, follow-up of each request for screening, and confirmation of treatment when screening indicates an abnormality and a referral is made.
- o Evaluation and management components to determine morbidity patterns, carry out cost-effective screening procedures and techniques, issue internal reports, identify program and/or provider weaknesses, and satisfy comprehensive Federal reporting requirements.

Given the considerable complexity of interagency coordination demanded of States, and the newness of the requirement to do active outreach, the full cycle of program implementation may require as much as four to five years; the program is now approximately two years into that cycle. Thus, within two to three years, the program should be able to focus on substantive objectives. Additionally, there should be sufficient data and program management experience to begin a comprehensive evaluation of the entire program in terms of those objectives.

As the EPSDT program matures, it will be increasingly necessary to view it as the Medicaid program for individuals under 21 which builds a full program on its preventive care base. In order to evaluate the impact the mature program can have on patterns of health care, it will be necessary to have a more complete picture of all Medicaid health care delivered to eligible individuals. Periodic screening and directly associated diagnosis/treatment are only one part of that picture. Beyond a basic core of crises requiring emergency room care (accidents, broken bones, etc.) which would presumably be roughly equal for all children, whether or not they are receiving EPSDT services, there is a wide range of inappropriate or high cost care

in which the case management and health education elements of a functioning EPSDT program can have a great impact. Linking a Medicaid family with a specific clinic or physician, where possible, can help avoid unnecessary and costly emergency room care for those conditions which do not require emergency care. EPSDT should not become yet another unrelated piece of an already fragmented health care system; it should be an opportunity to integrate all Medicaid services for eligible individuals under 21.

As a final note, it is important to point out that full implementation of EPSDT is not inconsistent with the serious need to control Medicaid expenditures. EPSDT is designed to prevent the long term consequences of untreated problems in children. A reduction in illness, by definition, reduces the need for costly health care services. While full implementation of EPSDT may involve front end costs, the potential long term gain is well worth the investment.

HISTORICAL DEVELOPMENT AND PROGRAM ACCOMPLISHMENTS

A serious commitment of Departmental resources to the EPSDT program dates only from about mid-1974. A fairly impressive amount of progress has been made in the past two years, however, and a sense of momentum has developed as States take on more and more active management of the program. Using the volume of children screened as one measure of growth, since it reflects children introduced into EPSDT, there were more screenings in FY 1975 (about one and a half million) than in the several years prior. The number of children being screened per quarter is now approaching one-half million. By the end of June 1976, approximately two million additional children will have been screened, for a total since program inception estimated at more than five million. As the program matures, especially in States with excellent programs, this annual volume includes more and more rescreenings in terms of the State-defined periodicity schedule. Data on the total number of screenings will eventually be separated by initial and periodic screenings so that a better measure of new program entrants is possible.

The findings from the early years of the program are:

Children referred for diagnosis		40-50%
Of those referred, the following problem areas were found (many children had multiple problems):	Vision problems	9-10%
	Hearing problems	2- 3%
	Dental problems	23-25%
	Lead poisoning	0.5%
	Other problems	35-40%

Unfortunately, comparable data is not available on the number of children referred who have actually received the diagnosis and treatment indicated by screening. While it is largely assumed that these services are being provided by the on-going health care system, this assumption cannot yet be verified. However, a number of States have, without direct Federal pressure, implemented systems which assure linkage between screening, diagnosis and treatment, and which provide States more knowlede of what is taking place. This step is highly significant since it indicates that EPSDT is being handled more as a service delivery program which assures health care than as an adjunct to a reimbursement mechanism.

Although not quantifiable, there are other indications that the program is catching hold. At least one State is giving increased attention to the accuracy of the results of their screening process, since this is a major factor in physicians' willingness to participate as providers. Another State is attempting to launch a more ambitious program than EPSDT by trying to provide preventive health care services to all children in the State. At least one major city is beginning to successfully implement EPSDT in a school setting for school-age children. Other States are making various program linkages to the developmental disabilities program of the Office of Human Development, for example. These less than precise measures of program momentum are important at the current level of program maturity since they indicate what is possible in certain kinds of settings, and provide leads for technical assistance to other areas of the country.

There is also a good deal of unplanned variation from State to State in program implementation. While this causes many problems, there are positive aspects which can be built upon. It will be essential in the next several years, however, for MSA to observe what is taking place in the 53 jurisdictions, begin to evaluate the most effective methods, and provide incentives for States to adopt those methods. There is no inherent advantage in having 53 different programs just because there are 53 separate jurisdictions. What is important is effectiveness in reaching the target population; the Federal level can play a catalytic and a facilitating role in this process.

A major commitment of SRS resources to technical assistance through the Community Health Foundation has had many benefits for the program. Twenty-three States have requested assistance through this contract, which has been well received since it offers high-level professional assistance (including medical) which the Federal government cannot provide directly in great depth. Having a large portion of direct technical assistance provided by contract has also alleviated the problem of Regional Office staff performing dual roles as penalty assessors and providers of technical assistance; States naturally do

not reveal all their faults to someone looking for penalty-liable violations. It also resolves the problem of frequent Regional Office staff turnover and concomitant lack of staff sufficiently skilled to assist States.

The penalty, and the commitment of DHEW to the penalty program that it represents to States, has been a major contributor to program implementation over the past two years. No money has yet been withheld, but the penalty was not provided by Congress for the purpose of recovering Federal funds. The political and organizational impact is still being felt in those States where a penalty has been announced (nine for first quarter, FY 1975; one for second quarter) and will be felt in States which have not yet been penalized. Even as late as last year there was a sense of unease about the penalty liability of many States beyond those being formally found out of compliance. MSA is now more confident that the penalty assessment process is finding most of the States with major problems and not unfairly overlooking serious violations. Even States that have proved most recalcitrant in the past have significantly altered their programs under pressure of the penalty.

Over the past year there has been a considerable amount of contact with States, especially in connection with proposed revisions to the penalty regulations in which meetings were held with more than 40 States. MSA is moving cautiously in revising the penalty regulations since the potential impact the regulations could have on States' programs is realized. The dialog with States has revealed that many of their concerns with the regulations stemmed from misunderstandings. (No State expressed direct opposition to the EPSDT program itself.) This open process was an opportunity for the Federal level to clarify intentions and program purposes directly with States and was mutually beneficial. Progress has been such that discussions center primarily on how best to carry out the penalty provisions and how to achieve a quality program. By again publishing the revised regulations based on State comments as proposed rulemaking, the process remains open for further State input.

A more defined way for the SRS Regional Offices to provide positive program development assistance to States has been initiated over the past year. First, each Regional Office analyzes the EPSDT program in each State, based generally upon knowledge and data gained in the course of penalty assessment visits to the State and a sample of counties and recipients. This analysis should probe the major barriers to full program implementation and the causes of the barriers. Second, a program improvement plan is developed with the State to identify and correct barriers within the upcoming year. Concurrence by the State is secured and the plan provides the basis for Federal-State

contact over the operating year. Third, a technical assistance plan is developed to indentify areas where the State needs outside assistance, the type and source of such assistance, and the Regional Office's plan for securing the assistance. These plans become a focal point of contact between Regional Offices and the MSA Central Office regarding each State's program. After the first year, most Regional Offices had completed a first round of these plans. In the upcoming year, further refinement of the process is required to make these plans contribute more effectively to program implementation.

PROBLEMS AND IMPEDIMENTS

Despite the progress noted above, there remain a few States and probably more counties (or equivalent local jurisdictions) that lack a basic EPSDT program. For purposes of this document, a basic program means one that meets minimal Federal regulations by informing eligible recipients and making services available on a timely basis upon request. Problems in this area are still being uncovered as part of the penalty assessment process, although the major gaps that characterized the findings in the first year of penalty assessment are not as prevalent. For example, during FY 1975 entire counties had no EPSDT program at all, or a State may have failed to inform large groups of eligible recipients about program benefits. During FY 1976 more complex and less obvious problems are being found. For example, in first quarter FY 1976 one county was offering EPSDT services to children under 5 and those over 12 -- but not to those between 6 and 12. Assuring a basic program in all parts of the country will be done by continuing comprehensive penalty assessment, especially at the county and local level. It should be noted that in many States there is insufficient staff at the State level to assure uniform compliance in a large number of counties. The Federal presence in counties, then, serves to augment State capacity to monitor at that level. The fact that Federal presence can lead to a penalty call should encourage the States to develop their own monitoring capacity to avoid the penalty.

There are also States which mismanage or badly plan their EPSDT or Medicaid program, find themselves with insufficient funds for a quarter or more (until the legislature meets), and are penalty liable on a one-time basis. However, we have seen little indication so far that the fiscal problems facing many States' Medicaid programs will be a major source of penalty citations.

Additionally, the EPSDT program is still several years away from being a well functioning, high quality service delivery program in all jurisdictions. Major barriers to achieving that objective are discussed below.

Some States and localities still regard EPSDT as a "screening program" with no connection to other parts of the health care delivery system. Some physicians perceive the program as a threat or a waste of time since diagnosis and treatment are not integral to the program as it exists in their locality. At worst, screening services can become another fragmented health service. While this is not the intent of EPSDT, lack of guidance by the Federal government to the program in the early years has exacerbated the situation. To some extent, Federal reporting requirements, which required only screening data, contributed to State misunderstanding.

Lack of adequate coordination between the various major actors at the Federal, State, and local levels is a major shortcoming. At the Federal level there exists a myriad of programs for children and child health, each with its own target population and purpose, and with varying degrees of statutory, regulatory, or traditional barriers to collaboration with other programs. At the State level, the Medicaid agency which is responsible for EPSDT is often the welfare department; the primary source of screening services in many States is the health department; and treatment is recived from the traditional provider community. These organizations and/or groups have often never attempted to work together and find that EPSDT makes unusual and precedent-setting demands on their bureaucratic capacity.

In some States there is little or no integrated State-level management of the program. In other States, as indicated above, only the screening portion of the EPSDT program is functioning, and case management capability is lacking to tie into other parts of the program. At the local level all of these problems manifest themselves in a very direct way. At worst absolutely nothing happens--despite nominal compliance with penalty regulations. Recipients are informed, but are not knowledgeable about the program and therefore do not request services; no agency functions to bring people into the program; screening capacity is underutilized, overutilized, or not utilized at all; and there is no assurance that needed diagnosis and treatment take place or that recipients find follow-up health care appropriate to their needs. Another consequence of the lack of case management is the inability to assure the periodic rescreening of recipients in accordance with the State's periodicity schedule. This means that very young children who should be screened more frequently receive only sporadic screening services, which greatly reduces the potential value of screening.

States also have insufficient data to plan or manage their EPSDT program, or to evaluate its impact. In most States the data exist in various places, but are isolated and seldom used for active management purposes. Beyond the data generated directly by the EPSDT and Medicaid

programs, there is also a need for broad information about health care resources, and their distribution and quality, which would permit identification of and action on such problems as provider scarcity or non-participation, and coordination and integration with other programs such as Title V, Maternal and Child Health, or school health programs.

Provider shortage and maldistribution are problems which EPSDT shares with other health care programs, but which are especially noticeable in a program of this type because it attempts to provide a broad population with services rather than define a population group to fit available services. Resources for screening are less a problem than treatment resources, since screening may effectively be conducted by nurses. A large number of States utilize their public health departments to provide screening services, often with large numbers of paraprofessionals involved. Treatment resources, especially dental, are a major problem since many areas of the country are underserved by dentists and primary care physicians. In many cases, however, the problem is one of access to resources, not necessarily a shortage. As more physicians learn about the EPSDT program and are willing to utilize screening findings as a service to them and their patients, similar to laboratory services, they are more likely to become EPSDT providers.

Lack of an aggressive outreach program remains a major problem in a number of States. Only minimal effort is made in these States to overcome recipient fear, ignorance, or misunderstanding, and communicate the importance of early, preventive health care. A large number of States are reluctant to commit resources to the EPSDT program because of concern about potentially high costs, especially the costs of dental treatment. (Since most States have never offered dental services under Medicaid, there is a vast backlog of unmet needs.) Other treatment costs are also perceived as a potential problem, especially in States with large numbers of eligible children. Since actively finding cases and marketing preventive services results in higher Medicaid outlays in a time when State budgets are severely constrained, States are understandably reluctant to commit more resources in the short term when program benefits are often perceived as long-term.

High recipient no-show rates for screening and treatment appointments are another major complaint by many States. Health care resources are not properly utilized when this happens, and many providers are so disappointed by recipients that they decline further participation in EPSDT. However, any health care provider must deal with some no-shows; many private dentists, for example, charge patients for lost time if they fail to show. The rate for no-shows at screening is higher than it should be, but Medicaid-eligible families are probably less familiar with the concept of preventive medicine than the rest of the U.S. population, and lack of transportation and social services such as day care

can also be an inhibiting factor.

Health education is not yet a strong part of the EPSDT program, though there is a great opportunity to use the well-child screening contact to provide parents with direct feedback from the screening as to the possible conditions found and their cause. Nutrition, hygiene, sanitation, and other health education areas can also be discussed to give the recipient a better understanding of health and related concerns (family planning could be discussed with a teenager, for example). Health education in turn helps assure that needed diagnosis and treatment are received and that the child returns for periodic rescreening. In addition, much more needs to be done to integrate health supportive and health related services from the recipient's point of view. Many health problems can be environmental; a high lead poisoning area, for example, would benefit more from a coordinated effort to renew old housing and eliminate lead paint than from continued treatment of lead poisoning symptoms.

CURRENT STATUS

Over the next two to three years the objective of the program will be full implementation in all jurisdictions. MSA's plan for achieving this objective consists of three major strategies: positive program development activites; continued monitoring for penalty compliance; and knowledge development. Each of these is discussed below and will form the basis for EPSDT objectives in the Department's Operational Planning System (OPS) and SRS Work Planning on a year to year basis.

In the first strategy area, positive program development, the Department has promised major support to States in implementation of the EPSDT program for the past two years. In FY 1976 major steps were made to provide this assistance. More needs to be done, however, since most States feel that the Department's primary emphasis is the penalty.

The penalty assessment process has recently been shifted from a quarterly basis to every six months for States which do not appear to be penalty liable, which will permit more staff time, especially in Regional Offices, for technical assistance and program improvement activities in the form of State Analyses, and Program Improvement and Technical Assistance Plans.

As indicated earlier, direct assistance to States by way of contract support is now seen as the most viable way to overcome problems inherent in a situation where Federal staff must play the dual role of auditor

(in the penalty process) and helper (in the technical assistance role). The current major effort with the Community Health Foundation is a major asset to the program, but contract funds permit assistance only to nine of the twenty-three States which have requested assistance. This effort should be continued at an increased level over the next several years.

A series of technical assistance pieces called "EPSDT in Action" has just been initiated and will be expanded in the future to become a major vehicle for technology transfer between States. The first publication describes program administration and management in South Carolina. The next several years will be critical in this effort, and as many good practices as possible should be shared around the country while States are still exploring ways of implementing their program. A recent decision has made it possible to offer States 75% Federal matching funds for skilled medical personnel and health-related support staff for EPSDT. MSA will continue to encourage and assist States to utilize this match to build local-level outreach, follow-up, and case management capability.

Another major area of concern is the ability of States to bring health care resources together into a coherent program through systems and management techniques. Although individuals under 21 account for only about 20% of Medicaid expenditures, almost half of total Medicaid recipients are children. Therefore, improved management for this population will go far to improve the Medicaid program generally. A model management information system for EPSDT, which will be a major subsystem of the Medicaid management system, has been developed this year, and will be ready for major implementation during FY 1977. MSA will continue a major thrust to act as a catalytic agent among the Department and the private sector. Considerably more attention needs to be devoted to the social services which should accompany the kind of health services delivered by EPSDT. With the programmatic emphasis on prevention and comprehensive health assessment, EPSDT can assist in early detection of health problems which can be best solved by non-health resources and in the identification of high risk populations toward whom such resources ought to be directed. Malnutrition and lead-base paint poisoning are good examples of such problems. However, with such large numbers of children eligible for EPSDT, there is some danger that EPSDT might spread minimal services too thinly across a large population or create demands for remedial medical, social, and legal services beyond the capacity of current resources. MSA will attempt to integrate its efforts with other DHEW and Federal programs, especially Title V Maternal and Child Health programs, the Center for Disease Control immunization and lead-base paint program, the Office of Education, the Office of Human Development, and Housing and Urban Development's community development programs to better coordinate resource utilization and development

and to assist in building resource capacity through Medicaid reimbursement.

Developmental assessment is another major program element that will be worked on in the next several years. Given the great controversy and lack of professional consensus on what can be done in this area, a cautious and thorough planning approach is being taken with the relevant DHEW agencies and concerned outside organizations. A push for implementation is not anticipated until a firm Departmental position is worked out.

The most important of the positive areas, however, is the direct financial incentive for program implementation at the State level. The history of the program and the tremendous demands made upon States to implement, in many respects, a new program, should make MSA sympathetic to State concerns about costs. There are several major aspects to this:

- o Advance funding for start-up and capital costs for EPSDT should be explored. Costs of a mobile screening clinic, for example, are very high, and many States cannot raise the front-end capital required. Making advance funding possible should be a major step forward in improving the EPSDT program.

- o A higher match should be explored for screening costs, for vision, hearing and dental treatment costs, and for the increased (over Medicaid per se) management and outreach staffing improvements of the program. The dental costs are the largest cost category, and seem to be one of the major reasons why States hold back on full implementation of EPSDT. Staffing shortages also put serious strains on already overloaded workers in many States.

- o An increased Federal match should be explored to induce States to assure the completion of treatment programs despite lapse of eligibility for Medicaid. Many dental treatment regimens are not begun because the dentist does not want unpaid bills if the patient loses eligibility. An extension for up to four months beyond lapse of Medicaid eligiblity would cover most of these cases.

Those issues requiring increased Federal matching will be addressed separately at the end of this document.

With respect to penalty assessment, the second strategy, while the process is a largely negative one, there have been many positive benefits to the

program from its application. A great deal of effort has gone into making the penalty review process fair and equitable to all States, and less of a paper exercise for Regional Office staff. MSA will continue to improve its techniques for carrying out these responsibilities.

As indicated earlier, MSA is planning to publish revised penalty regulations to clarify requirements for State implementation of EPSDT. It has become clear that penalty-related requirements identify for many States the limits of their programs, since all States should be expected to be doing at least what the penalty regulations require. Since, however, they may not go beyond the minimum requirements, it becomes particularly important for program quality and effectiveness that penalty requirements, if adhered to, establish the basic program elements necessary to arrange for and deliver comprehensive health care to eligible individuals under 21. To do this, the regulations must establish requirements to address major obstacles to implementation, such as problems of inappropriate utilization of health care services, fragmentation and maldistribution of health care resources, and common health conditions of eligibles, through requirements related to effective informing and health education; health-related support services; timeliness in the delivery of medical services; and a comprehensive health assessment for all eligibles. As experience in EPSDT has shown, obstacles to the availability of health care services, particularly preventive services, include far more than lack of financial resources of individuals seeking care.

Information necessary for administering EPSDT at the State and local level to meet these basic program needs will also be identified. From this perspective, the penalty regulations can play a significant and positive role in overall program development and both correspond with and be supported by the initiatives in technical assistance, research and development, and cooperation with other DHEW components responsible for meeting health care needs of children.

In the third strategy area, knowledge development, major revisions have been proposed to the statistical reporting requirements on EPSDT which ask for periodicity, treatment, and cost data on the program. Such data is critical to MSA's ability to evaluate the effectiveness of the program in the future. In addition to program knowledge already obtained through demonstration project activity in screening; diagnosis and treatment; local organizational program management and staffing; case management; outreach; and health related supportive services, MSA plans to continue demonstration projects to "learn through doing" and thus expand knowledge of substantive areas of the program. The priorites are:

- The older child in EPSDT:

  (1) different ways of reaching the older child through the school, youth organizations and clubs, probation departments, recreational organizations, special programs for the handicapped, etc.;

  (2) substantive content of treatment plans including identification of problems relevant to the older child; content of appropriate health education, the level of staff that should be involved, methods of case management and follow-through;

  (3) provisions for dealing with special problems of adolescence, e.g., alcoholism, drugs, teenage pregnancy, etc.; and the development of a coordinated plan for provision of needed services with related community resources; and

  (4) enlisting interest and support of voluntary organizations especially concerned with youth, the schools, and appropriate professional organizations to plan for and implement an effective program meeting needs of youth within the parameters of EPSDT objectives.

- Implementing the developmental assessment and treatment component of the EPSDT mandate:

  (1) evaluating the different testing modalities for identifying developmental lags with specific reference to different age groups as a basis for providing technical assistance urgently being requested by the States;

  (2) how to develop the interdisciplinary approach needed in both the identification and further diagnosis of a suspected developmental lag;

  (3) the level of staff and appropriate training needed for carrying out the initial identification of suspected problems;

  (4) how to arrange for needed community resources, either through coordinating with existing, or development of new, resources; and

  (5) how to inter-relate with the many different organizations, associations, professional disciplines, and on-going programs for special groups of handicapped children to develop their support for EPSDT activities in this area, and to lend their expertise in the development of an effective program.

- o The role of the school in EPSDT implementation:

  (1) how to coordinate with existing school health programs in the medical component of EPSDT to avoid duplication as well as utilize existing resources effectively through reimbursement provisions;

  (2) how to coordinate with the special education programs now required (P.L. 94-142 - Education for All Handicapped Children Act of 1975 amending and expanding P.L. 93-380 of 1974) both in identification of handicapping conditions and in the provision of supportive services to carry out prescriptive treatment in conjunction with special education programs provided by the schools; and

  (3) the development and training of health aides and other supportive staff in carrying out this coordination.

- o Interagency collaboration:

  (1) how to coordinate EPSDT with other related interagency programs so that available resources can be utilized most effectively; and

  (2) initiation of joint project activity in areas of mutual concern with Bureau of Education for the Handicapped, Health and Nutrition and other appropriate units of Office of Education; Developmental Disabilities; Maternal and Child Health and other appropriate units of Health Services Administration; Health Services Research Center in Health Resources Administration, Health Education in Center for Disease Control; President's Commission on the Mentally Retarded; National Institute for Mental Health; Housing and Urban Development; Supplemental Security Income; etc.

As knowledge is gained in these areas and incorporated into positive program development efforts, the EPSDT program will be able to move closer toward the achievement of its substantive objectives. Together with more effective penalty regulations and reviews, these strategies form the EPSDT Forward Plan.

ISSUES

There are five issues in the EPSDT program which must be addressed. They are:

(1) Should the Federal Financial Participation (FFP) rate for EPSDT be increased, and, if so, to what level?

(2) Should the Federal match for dental services be increased?

(3) Should eligibility be extended for individuals under treatment programs which begin as a result of EPSDT?

(4) Should there be a separate authorization and appropriation under Medicaid for research and development, capacity building grants, start-up funds, and manpower training related to EPSDT, Medicaid and health-related support services?

(5) Should advance funding under Medicaid be made available for EPSDT-related expenditures?

The Medicaid program, as originally conceived, assumed that the nation's poor could get better health care if financing were made available so that the poor could buy their health care in the market on an equal basis with the more affluent. The mechanism for achieving this was to make grants to States to subsidize, or in some cases expand, their on-going medical assistance programs. The Social Security Amendments and subsequent legislation and regulations which created the EPSDT program went beyond this original Medicaid charter by: (1) adding new medical or medically-related services (vision, hearing, dental treatment, and periodic screening services), and (2) requiring the State to take active steps to assure that services are delivered in a timely manner.

At first glance these additions seemed to be merely new required services under Medicaid. Experience has shown, however, that these services were not readily available in the health-care marketplace and that the management problems associated with health service delivery are complex. This is especially true in the case of outreach services, where there is little hope that recipients will achieve access to and full participation in the EPSDT program unless States establish effective outreach systems. Demonstration projects and other efforts utilizing intensive outreach have resulted in response rates as high as 90-95% of those contacted. However, it is often impossible to assign outreach tasks to already overburdened State staff; in many States, allocations to hire new staff are either non-existent or extremely difficult to obtain. Finally, some of these newly required services are expensive (dental treatment, staffing) and strain already hard-pressed State Medicaid budgets. An increased Federal match is an option for dealing with those problems. While an increased match for all Medicaid administrative costs is discussed earlier in the Forward Plan, the pros and cons relating specifically to EPSDT are discussed below.

There are several factors which support an increased match for EPSDT. An increased FFP to States would be fair since EPSDT represents a complex requirement that is more demanding of States than originally thought or intended. States cannot be expected to successfully implement a complex program by Federal fiat alone. Increased FFP would provide the most needed ingredient in EPSDT implementation, as seen by States at the present. Program managers in States would find EPSDT easier to sell to legislatures if the Federal financial commitment were greater. Increased FFP would redress the current Federal emphasis on negative sanctions and provide a balanced, constructive approach to Federal-State relations on EPSDT. Finally there is precedent for higher matching rates, notably Family Planning (90%), which have been provided as special incentives.

On the other hand, Federal statutes require the EPSDT program and States are capable of implementing it. No additional incentives should be required. Any increase in FFP further tilts the fiscal balance of the program to the Federal side and could be considered unwise in a Federal-State partnership. Fiscal constraints and inflation in the health care area could also preclude funds from being available.

If an increased FFP is approved, the level of the increase must be considered. A Federal FFP rate of 75% would be an increase for most States for service, and an increase for all States for administration and program management (now at 50%, except for certain staff under skilled medical supervision for which 75% is currently available). One difficulty with the currently available 75% match for staffing is that the increased bookkeeping requirements appear to States to eliminate any advantage in the higher rate. In addition, many States have difficulty raising the remaining 25% in a period of tight budgets. Increasing the entire EPSDT match would make the higher rate very attractive.

There is, however, good precedent for an even higher FFP established by the 90% match for family planning services. In this case the Federal government had a high priority program and was willing to pay a high match to see it implemented. The same commitment should be made to the EPSDT program. Performance criteria could be developed administratively to be applied to States' activities as a measurement of whether or not they should get the 90%. As a minimum, no State that is penalty liable would be eligible for the increased matching. Further, MSA would need assurances that the State had effective procedures for informing, outreach, screening, treatment, and follow-up, making maximum use of existing resources and screening a reasonable percentage of children each year.

Finally, full Federal financing at 100% would be the best rate from the States' fiscal point of view. However, at this rate the State would have little stake in the program, yet Federal control would remain limited, as long as the program is State managed.

It is recommended that SRS develop a legislative package to increase to 90% the FFP rate for all EPSDT services and administration.

The second issue is whether the Federal match for dental services should be increased. For many States, dental services are provided only for the EPSDT population. Dental services are typically not included in health insurance programs. Yet, in EPSDT, a minimum of 25 percent of all screened children have been found to have serious dental problems, and at least one State has decided to send children directly for dental work since their experience indicates over 90 percent with dental problems. It seems clear that the dental problem is of great magnitude, especially for the needy children serviced by this program. States fear the potential costs sufficiently that it blocks full implementation and commitment to EPSDT.

Increased FFP to States for dental services could be tied to successful implementation of a Statewide fluoridation program and to a 60% penetration rate (60% of Medicaid-eligible children utilizing dental services in a State).

In 1971, generalizing from data on national dental caries experience, the costs of treatment services, the benefits known to be derived from fluoridation, and the per capita costs of fluoridation, the Public Health Service (PHS) estimated that savings in children's treatment costs for dental caries would be $36 for every $1 expended on fluoridation. And this estimate does not take into account the benefits to primary teeth, the reduced need for certain diagnostic services, or the benefits which will accrue in later years of life.

An extremely conservative PHS estimate has been made of the national savings which could be realized if universal fluoridation were in effect at the start of a National Health Insurance (NHI) program providing basic dental benefits for children and adolescents up to 18 years of age. Assuming 100 percent fluoridation coverage of NHI, at least $2.6 billion in dental services costs for persons 18 years and under would be saved over the first 15 years. By the 15th year, the annual cost reduction would reach $437 million, with larger reductions still to be shown when the full benefits of fluoridation reached the last of the ages covered by NHI. For children under 13, the savings in dental services costs would aggregate an estimated $1.5 billion, and by the 15th NHI program year, the annual cost reduction would be $190 million.

The criteria to qualify for 90% FFP would be as follows:

A. For States with Statewide fluoridation laws, increase would be immediate or upon effective date of law.

B. For other States, increase would be phased in over three-year period.

1. For States with 60% utilization or more--increase would be in first year.

2. For States below 60% utilization

- Whichever comes first -- 60% or three years, or

- 30% first year; 30% second year; 40% third year, or

- Proportionate to increase in utilization rate between current level and 60% minimum

C. There should exist no State policy that a physician must refer for dental care; referral should be directly to dentists.

The rationale in support of the proposal is that States which have weak dental components would improve their services to children; more children would receive dental services; States which hesitate to commit themselves to EPSDT generally because of potential dental costs will be less hesitant; the Department would offer a positive incentive to States as opposed to the negative posture associated with the penalty; the precedent for a 90 percent match rate has been established in family planning; and potential long term cost savings are significant.

On the other hand, costs to the Federal government would increase annually by an estimated increase of $100 million (Federal share), and dental care is already required, so SRS could just enforce the requirement.*

It is recommended that SRS give serious consideration to developing legislation necessary to increase FFP for dental care to 90 percent for a period of three years or until the backlog of unmet need in States is reduced.

* It is assumed here that utilization of dental services would double if the FFP rate were increased, from the estimated $80 million per year total to about $160 million. The Federal share would increase from $45 to $145 million. The $100 million increase is approximately equal to the amount which would be saved if FFP for adult dental care were withdrawn.

The third issue is concerned with whether eligibility should be extended for individuals under treatment programs which begin as a result of EPSDT to ensure continuity of care. This is important for two reasons. The obvious consideration is that incomplete treatment is at best no treatment at all; in many cases it is worse. Treatment providers (private physicians and dentists especially) are understandably wary of beginning a treatment program for which there may finally be no reimbursement. The result is an unwillingness to participate in EPSDT (or Medicaid) or fragmented care. In the EPSDT program there is an obligation to provide treatment; if screening uncovers a condition requiring extended treatment, then there appears to be a corresponding obligation to provide it.

The advantages of this proposal are that recipients, providers, and States can be assured that reasonable treatment programs will not be interrupted and will be paid for; providers who question the artificialty of eligibility criteria for the continuum of needed medical care will be more likely to participate; the goal of quality and comprehensiveness in EPSDT will be supported by filling a gap in our ability to assure treatment for conditions; and screening resources will be maximized.

On the other hand, some marginal new costs would be incurred, although they are difficult to project; States should cover such cases themselves out of State revenues; and an accountable mechanism for identifying pathological conditions uncovered for the first time as a result of the screening process would be difficult to create.

It is recommended that the Department give consideration to seeking legislation to extend eligibility where necessary for four months of treatment, including financial incentives (increased FFP) if required to induce States to assure such treatment.

The fourth issue is whether there should be a separate authorization and appropriation under Medicaid for research and development, capacity building grants, start-up funds, and manpower training related to EPSDT medical and health-related support services. Scarce and uncoordinated health care resources are a major problem in implementing the EPSDT program. The current Sections 1110 and 1115 of the Social Security Act allow some flexibility and funding for demonstrating various ways to coordinate resources, but little for start-up or seed money to encourage States to actually implement effective ways to coordinate EPSDT resources. States may feel that a demonstration idea is worthy, but lack the funds to implement it. MSA can finance only through the reimbursement mechanism, after services are delivered; this is the great limiting factor in the ability to help build more resources and encourage greater collaboration between programs. EPSDT, of course,

shares this problem with Medicaid and other health care programs. However, the history of EPSDT, which includes an amendment to Title V of the Social Security Act to encourage efficient use of resources, makes it an especially appropriate forum to deal with the problem. Flexible funding would be targeted to resource creation and coordination in support of EPSDT implementation.

There are several factors which support this proposal. First, without outside stimulus, there is a tendency in States to take health care resources as given and make no effort to change them. This proposal would allow direct stimulus to the creation of resources or significant change in their utilization. Second, the current source of research and demonstration funds assumes States willingness to adopt and pay for new service delivery modes. This proposal would assist in paying for the development of new resources. Third, the Congressional Budget Office may recommend this type of approach to the House Budget Subcommittee.

On the other hand, States are responsible for EPSDT implementation and should be capable of developing health care resources needed for the State. This proposal could represent Federal intrusion. The proposal could also violate the Federal-State partnership nature of the Medicaid program, which includes EPSDT. Funding for capacity-building of this sort is currently the responsibility of the health agencies of DHEW, not SRS. Finally, Funding is not readily available in an already tight Federal budget.

It is recommended that consideration be given to developing a formal request for capacity-building support of the EPSDT program for submittal to Congress.

The fifth issue is concerned with whether advance funding should be made available for EPSDT-related expenditures. This issue will not be fully developed here. It is included to indicate the importance of the overall Medicaid advance funding issue for EPSDT. Certain high capital cost items like mobile screening vans or mobile dental clinics are crucial in many rural States. The costs of these items can be amortized as services are delivered, but many States have difficulties with the initial funding. It is our understanding that the policy related to advance funding has been under review by the Department of the Treasury and the Comptroller General.

It is recommended that vigorous Departmental support of this policy and legislative changes be urged to make advance funding under Medicaid available to States as soon as possible.

In conclusion, the major EPSDT program strategies, positive program development efforts, continued penalty assessment, knowledge develop-

ment, and financial incentives to the States are designed to achieve full program implementation. Since the EPSDT experience has significant implications for national health insurance, the success of its implementation will be of considerable importance in future debates on the issue.

LONG-TERM CARE

CHAPTER 5

DEFINITION AND SCOPE

Long-term care (LTC) generally refers to those health-related services provided to persons debilitated by old age, illness, or disability over an extended period of time. Long-term care provided under the Medicaid program consists of institutional services in the form of skilled nursing facility (SNF) and intermediate care facility (ICF) services (including care of the mentally retarded in ICF's) and community services such as those provided by day treatment centers, day hospitals, and home health agencies.

HISTORICAL DEVELOPMENT

Until the enactment of the Medicaid law in 1965, States provided care for public assistance recipients in nursing homes by including the cost of care as an element in the direct money payments to recipients or through direct payments to vendors (first authorized in 1950). By March 1960, nursing home care was provided by 49 out of the 54 jurisdictions; 13 used the vendor payment method, 8 used both the vendor payment and money payment method, and 28 used the money payment method exclusively.

In 1960, the Kerr-Mills Medical Assistance for the Aged (MAA) law was enacted under which States could provide medical care to a new type of "medically indigent" persons who were not recipients of public assistance but who were 65 or older and met certain State-established income and resource requirements. By June 1963, of the 29 States that had come into the new MAA program, 7 did not cover nursing home care, while others imposed severe restrictions such as limitations on the maximum payment made to the homes, coverage of only acute or emergency medical conditions, or provision of care only in public facilities.

In an effort to alleviate the serious lack of care available to needy persons, Congress enacted the Medicare and Medicaid laws in 1965. Under the national Medicare program, nursing home care (then known as "extended care facility services") was available during a convalescent period following hospitalization. Under the Federal-State Medicaid program, States could limit their programs to "some institutional and some non-institutional services" until July 1, 1967; thereafter,

they were required to provide skilled nursing home care and four other mandatory services. Changes in the Medicaid LTC program made by the Social Security Amendments of 1967 included a requirement that recipients be given freedom of choice of qualified providers, that skilled nursing homes meet certain environmental and life safety standards, that State agencies undertake a regular program of professional medical review (including an evaluation of the appropriateness of care given to each Medicaid patient), and that each nursing home administrator be licensed by the State.

In 1971, legislation was enacted transferring authority for provison of assistance in the form of institutional services in ICF's from Section 1121 of the Act to Title XIX, the Medicaid law. The new authority included coverage of ICF care in public institutions for the mentally retarded or for persons with related conditions (ICF/MR).

Further amendments affecting LTC were included in the Social Security Amendments of 1972. These amendments required that (1) health standards for institutions be established and maintained by the State health agency or by the State agency utilized by Medicare, (2) SNF's meet Medicare standards in Section 1861(j) of the Act, (3) the State or local agency used by Medicare also be used by Medicaid to determine whether institutions meet the requirements for participation in the program, (4) Federal on-site surveys of institutions be conducted, (5) survey findings be publicly disclosed, (6) as of July 1, 1973, ICF's must supply information to the State agency as to ownership, (7) as of July 1, 1976, payment of SNF and ICF services be determined on a reasonable cost basis, (8) reasonable cost differentials between Statewide average reimbursement rates for SNF and ICF services be maintained (no longer required), (9) a program of review of utilization of services be instituted, (10) a program for medical review of the care of patients be instituted for SNF patients, and (11) annual independent professional review of professional management of each case be instituted for residents of ICF's.

At the present time, it is estimated that approximately 40% of Medicaid expenditures are for LTC. In fiscal year 1976, for example, the Federal share was $3.1 billion out of a total expenditure of $8.3 billion. During the period August 1973 to April 1974, there were 12,100 SNF and ICF institutions serving approximately 600,000 eligible individuals.

CURRENT STATUTORY REQUIREMENTS

The principal statutory requirements relating to LTC under Medicaid are the following:

1. Each participating State must provide skilled nursing (SNF) and home health services for all recipients age 21 or older. Intermediate care facility (ICF) services are optional. There are no limitations on length of coverage.

2. States must assure that recipients are given freedom of choice of qualified providers.

3. States must meet the requirements for licensing of administrators of nursing homes. Every facility to participate in the program must be administered by a licensed administrator.

4. SNF's receiving Medicaid payments must satisfy all requirements on standards for participation in Medicare under Section 1861(j) of the Social Security Act.

5. The State or local agency used by Medicare or the State agency responsible for the licensing of health institutions will determine whether institutions meet the requirements for participation.

6. The Secretary must conduct sample on-site surveys of qualified institutions and make the results available for public inspection.

7. States must have an agreement with each institution that it will keep records and give information.

8. States whose plan covers ICF services must provide for disclosure of certain ownership information.

9. States must establish a plan for review of appropriateness and quality of care furnished to recipients.

10. States must provide for a regular program of medical review (including medical evaluation) of each patient's need for SNF care, a written plan of care, and, where applicable, a plan of rehabilitation prior to admission to a SNF.

11. States must provide for periodic inspection in all SNF's by medical review teams.

12. If a State covers ICF services, it must provide a program of independent professional review (IPR), a written plan of care, periodic on-site inspections of facilities by

independent IPR teams, and complete reports of the inspection findings.

13. The Secretary must decrease the Federal medical assistance percentage if a State does not have in operation a program of control over the utilization of services. Several specific items of activities which must be performed are stated in the Act.

14. States must pay for SNF and ICF services on a reasonable cost-related basis.

15. The Secretary will not provide FFP for any expenditures made by a State to an ICF which does not meet the statutory definition of an ICF or of an ICF for the mentally retarded nor for any ICF services which do not meet the statutory definition of "ICF service".

16. The Secretary will not provide FFP in expenditures incurred for services provided by an institution during the effective period of any order for the suspension of payments.

17. States must provide nursing facilities with consultative services by health agencies and other appropriate State agencies.

Pertinent regulations on LTC appear in Title 45 of the Code of Federal Regulations.

BROAD OBJECTIVES

The broad objectives of the Department's policy in long-term care have never been expressed in definitive terms. Indeed, the policy of the Administration toward care of the elderly is fragmented, incomplete, and not well coordinated. The various proposals for National Health Insurance, likewise, have not adequately addressed the problems of the chronically ill aged.

The broad objective of Medicaid's long-term care effort could be stated as striving to improve the quality of life of needy persons who have infirmities, maximize their potential for self-dependency, and promote the maximum well-being of persons for whom we provide care. It is our objective to provide necessary medical, remedial, and supportive services to eligible recipients in an appropriate modality, of high

quality, and in a setting which is safe and a good environment. At the same time, we are striving to promote efficiency and economy in the use of scarce resources. By the proper placement of individuals in the appropriate care setting, we hope to achieve maximum health benefits at minimal cost. We believe it essential that the needs of each recipient be assessed by a physician or a team of appropriate professionals to determine the specific needs of the individual, to develop a plan of care for her, and to assure that she is placed in the appropriate setting to receive the care, whether it be in a skilled nursing facility, an intermediate care facility, or her own home. Long-term care does not necessarily mean institutionalization as this is often not the best way to provide the treatment needed. Unfortunately, in all too many cases, institutionalization is the only recourse because of a lack of appropriate alternatives.

While the characteristics of an "ideal" long-term care system have never been fully developed, the components of an ideal system would include a full range of medical, social, rehabilitative, and personal services for the long-term care of the needy. It should provide for a continuum of care which would protect the person whether he is in his home or in an institution. Any model system for delivery of long-term care should be based upon community or regional coordinating agencies to provide the complex array of services needed tailored to the individual needs of recipients. The reimbursement mechanism must be adequate to attract providers, or better still, local service agencies could be reimbursed on a capitation basis.

CURRENT ACTIVITIES

Life Safety Code

The Life Safety Code is a consensus standard developed by the National Fire Protection Association and is in wide use in States. The Code represents advanced scientific and technical thinking in the area of institutional fire safety. Facilities wishing to participate in the Medicaid program must meet the provisions of the Life Safety Code. Long-term care staff will be conducting training sessions for Regional Office and State personnel in the application of the Code. Staff in the Medical Services Administration's Division of Long-Term Care are members of the DHEW Technical Codes and Standards Committee. The goal of this committee is to provide uniform and consistent application of the Life Safety Code standards on a Department-wide basis. The Committee also has responsibility for (a) rendering interpretations and clarification of the Life Safety Code and related codes as applicable to facilities participating in the Medicaid, Medicare, or Hill-Burton programs, (b)

analyzing and resolving intergovernmental differences or ambiguities involving the technical codes or facility standards, (c) providing an organizational mechanism by which the official DHEW position can be developed, defined, and conveyed, and (d) devising a standardized publication system for the orderly compilation and distribution of Committee decisions and technical bulletins.

Medical Review/Independent Professional Review

There are currently two Medicaid requirements directed at quality of care assessment, medical review (MR) for SNF's and independent professional review (IPR) for ICF's. The MR requirement has been in effect since 1971 and IPR since 1974. While these two reviews are distinct in that they are used for two different types of LTC patients, they have certain commonalities. Simply stated, they both require a team of State professionals (physician and/or nurse, social worker) to visit Title XIX facilities at least annually to evaluate the quality and appropriateness of care received by each Medicaid patient who is receiving long-term care. The requirement can be met only through personal contact and direct observation of each patient by a member of the team. This actual observation of and communication with the patient is an aspect unique to MR/IPR. All other Federal reviews, including PSRO initiatives, are based on medical records and abstracts recorded on forms usually completed by nursing staff or physicians. It is only through contact with the person involved that the quality of life for that individual can be reasonably assessed.

In addition to this personalized, responsive approach to patient assessment, other benefits accrue from MR/IPR. These may be fiscal such as by the team's recommending a change from a more costly SNF to a less costly ICF. Another benefit may be increased understanding of the Medicaid program brought about through liason of State physicians with private attending physicians in discussing team findings about a particular patient. Another may be increased community understanding of Medicaid brought about through the social worker's efforts to allay a patient's concern about a relative in the area. In order to assure that the LTC patient's needs are met, knowledge of their characteristic physical, mental, and social status must be obtained. Much of this care can only be obtained through interviewing the patient. These reviews should receive greater attention and effort from MSA and the Department because the reviews are designed to determine the patient's well-being in contrast to all other reviews which are directed at the facility. Regional seminars for MR/IPR teams should be held focusing on the aging person and the characteristics of the LTC patient. Such seminars could well result in a self-examination by participants of their attitudes toward the LTC patient and contribute to the evolution of a new perspective toward the elderly.

Home Health Services

Home health services as defined in regulations consist of both skilled (nursing and therapy) and personal care (home health aide) services provided for individuals living in their own home who do not need 24-hour institutional care. They are provided on a part-time or intermittent basis ranging from an hour a day once or twice a week to as long as 40 hours a week for home health aide or personal care services. On a daily basis they may in some instances be more costly than the State's per diem rate of payment to nursing homes, but on a monthly basis they are usually far less expensive. In order to be effective as an alternative to institutionalization, the services must frequently be combined with such nonmedical items of assistance as homemaker, chore workers, or home-delivered meals. Strictly speaking, they are not in fact an alternative to any other type of care but should be recognized as an important segment in the continuum of care in a health delivery system. Home health services are appropriate for certain carefully selected individuals who have someone else available to give care between the visits of agency personnel. When properly used, they can prevent institutionalization and encourage early deinstitutionalization.

Home health services were an optional item of care in the original Medicaid legislation but were mandated for all States as of July 1, 1970, by the 1967 Amendments to the Act. Originally, the term was defined as any of the following: intermittent or part-time nursing, medical supplies and equipment, and home health aide services. When home health services became mandatory, few States, even those which provided only token services, changed their plan to increase the amount and scope. Today, very few States provide comprehensive home health services to all eligible patients.

In 1973, the General Accounting Office (GAO) published a report pointing out the differing interpretations States have applied to the home health regulations. As a result, the original home health regulations were rewritten as proposed rulemaking in order to specify the services that States must provide, to broaden the base of providers to include unlicensed proprietary home health agencies and single-service visiting nurse associations, and to prescribe a set of standards for the newly eligible agencies. Because of the provisions relating to proprietary agencies and visiting nurse associations, the regulations became quite controversial and were subject to many comments from the public. They have not yet been promulgated in final form as the Secretary is still considering the issues involved.

Day Health Care

Medicaid staff have had serious concerns about the growing use of nursing

homes for care of the elderly and disabled. We find that (a) many elderly and disabled persons are institutionalized without an objective assessment of either rehabilitation potential or possible suitability for independent living within their own community, (b) many are institutionalized inappropriately as a matter of expediency, and (c) our health care system is structured to provide primarily institutional services or physician and some home health services with little or nothing available between these ends of the spectrum. This leads in many cases to both premature and inappropriate institutionalization.

After studying the problem, the Medical Services Administration and the Administration on Aging joined forces to test a new type of service, that of medically-oriented adult day care. Four contracts were awarded in 1973: On Lok Senior Health Services (San Francisco, California), Levindale (Baltimore, Maryland), Mosholu-Montefiore (Bronx, New York), and Burke Day Hospital (White Plains, New York). The On Lok and Burke programs have successfully demonstrated that medically-oriented adult day care or day health services is a vital service for the elderly and disabled living in the areas served. We know that many individuals have benefited from the high quality health care provided and have either had institutional stay reduced or avoided because of the day health services being available.

In June 1975, under authority granted by Section 222 of P.L. 92-603, the Public Health Service in conjunction with Medicare and Medicaid awarded four 18-month contracts to test medically-oriented adult day care. Because the National Center for Health Services Research was unwilling to develop the Medicaid portion of these contracts and presented many barriers for Medicaid, there is a Medicaid sample in only one site, Lexington, Kentucky.

Currently, there is no Federal law defining day health services. Medicaid staff drafted proposed regulations in 1973 and circulated them throughout DHEW, but they were never published. In January 1976, the Social Security Administration published proposed regulations for day care as it was being tested under Section 222. These regulations were modeled after Medicaid's 1973 proposed regulations, but have not yet been published in final form.

The decision was made to begin with day health care for the elderly and disabled in an attempt to provide States with some relief from the escalating costs of nursing home care, currently consuming 40% of the national Medicaid appropriation.

Today there is increasing interest in day health care. States such as California and New York have taken steps to develop proposed State legislation. New York has passed a law and has implemented regulations

for such care; other States are moving to do the same. MSA staff is attempting to provide consultation to State Medicaid agencies and State health departments as they develop day health service programs.

Regional Office of Long-Term Care Standards Enforcement

Functions relating to the survey and certification of institutions are supervised by the Regional Office of Long-Term Care Standards Enforcement (ROLTCSE) under the Regional Director. This office oversees the activities of the State survey agencies (State health department) in relating to the certification of SNF's and ICF's, works closely with State survey agencies, and issues the waiver agreements for Medicare and Medicaid facilities. They are presently reviewing State survey agency activities relating to ICF/MR surveys and reporting progress toward the 1977 deadline for final certification. The reports of problems in ICF/MR are being prepared by ROLTCSE for submission to the Office of Long-Term Care (OLTC) where they will be reviewed by the OLTC and SRS to determine if changes are required in the ICF/MR regulations.

Office of Long-Term Care

The principal Medicaid-related activity within the Department outside the Medical Services Administration is that performed by the Secretary's Office of Long-Term Care (OLTC) which coordinates Departmental policy matters relating to long-term care. OLTC is now engaged in an activity which is called Phase II - Long-Term Care Facility Improvement Campaign. This is a long-term effort which is expected to last for four years. The project seeks to develop and test a patient assessment instrument to evaluate the actual care being provided the patient. In combination with a curtailed facility survey form, it will be used to measure a facility's capacity to provide quality care. It is hoped that the result will be a decrease in emphasis on facility certification and examination and/or increase in emphasis on the type and quality of care being provided to patients in SNF, ICF, and mental institutions. A by-product of the new effort is expected to be a lessening of the voluminous paperwork in certifying facilities for participation in both Medicare and Medicaid.

OLTC also has been developing a Management Information System (MIS) for long-term care which will be operational soon. This system is expected to have the capacity to produce voluminous data concerning nursing facilities including summary data on types and numbers of various facilities, numbers of recipients in the facilities, survey data including dates of surveys and re-surveys, as well as information regarding specific SNF or ICF facilites.

PROBLEMS AND ISSUES

Level of Care

The Medicare program is designed to provide a short-term extended care benefit for post-hospital patients who need acute care during a convalescent period. On the other hand, SNF services under Medicaid are not related to prior hospitalization, but are intended primarily for chronically ill patients who need long-term professional care in a medical institution.

On September 24, 1975, regulations were published in the Federal Register implementing a 1972 statutory amendment which established a single definition and set of standards for SNF's in Medicare and Medicaid. While this regulation has slightly liberalized the Medicare definition, it has resulted in a much more stringent one for Medicaid. Prior to the new regulations, MSA had restricted itself to defining the skilled nursing facility itself and had left each State free to develop its own definition of SNF services. The new definition has proliferated a number of new problems and concerns. For example, States which previously used a more restrictive definition claim they will now be put to additional expense by having to provide SNF care for patients not formerly eligible for them. States which had a more liberal definition feel they will need to reclassify patients and in many cases transfer them physically to ICF's. They know that such transfers are difficult for aged institutionalized patients and that they may in many cases suffer "transfer shock" with the concomitant possibility of an increase in the incidence of morbidity and mortality. There is serious concern as to who will be responsible for resolving differences where a Medicare fiscal agent makes a decision as to the need for SNF services and the State Medicaid agency makes a different decision in the same case. The DLTC believes the definition and criteria are ill-suited to Medicaid patients and believes the Department should recommend statutory change to the Congress so as to give recognition to the differing needs of SNF patients in the two programs.

ICF Care for the Mentally Retarded

In December 1971, Congress enacted a law transferring authority for the Intermediate Care Facility (ICF) program from the public assistance programs (Section 1121 of Act) to the Medicaid program (Title XIX) and adding to it ICF care for the mentally retarded (ICF/MR) in public institutions. An ICF is defined as an institution which provides "health related or rehabilitative care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing home is designed to provide, but who, because

of their physical or mental condition, require care and services above the level of room and board." Because of the unique needs of its residents, however, an ICF for the mentally retarded presents a special case. There are approximately 185,000 mentally retarded persons living in institutions today. Nearly half are children. Sixty percent are severely or profoundly retarded. For too many, the conditions in which they live constitute a shocking denial of human dignity. They all too often represent environments which do not permit them to grow, develop, or learn to cope with the circumstances of their human condition. Congress recognized the special needs of the institutionalized mentally retarded by stipulating in the ICF legislation that each resident must receive active treatment to be eligible for Medicaid support. Active treatment means an aggressive and organized effort to assist each resident to attain the fullest functional capacity of which he is capable. It requires an integrated, individually tailored program of services directed to achieving measurable behavioral objectives and has as its goal the development of those skills, habits, and attitudes essential to adaptation in contemporary society.

In order to obtain Federal money for their mentally retarded population, some States are beginning to transfer residents of State institutions for the mentally retarded to ICF's and SNF's which serve primarily a geriatric population where their special needs are not met. The Division is concerned that this State effort to circumvent the ICF/MR regulations is resulting in the substitution of Federal for State dollars and is thus not only in violation of clearly expressed Congressional intent, but is resulting in improper placement of recipients. Final regulations published in the Federal Register on January 17, 1974, require that ICF/MR's participating in State Medicaid programs must, by March 17, 1977, meet certain standards which are additional to and more stringent than those now required. Recognizing that many of the facilities will have difficulty in meeting the new standards, the Division believes it vital that a strong and immediate Federal effort be launched to assist States and Regional Offices in their efforts to meet the new requirements.

Patient Rights and Welfare

Current Medicaid long-term care program regulations recognize the need for the protection of certain rights of individuals in nursing homes. However, greater efforts will be required by the appropriate Federal and State agencies to protect these rights effectively, especially in the area of the possible abuse of personal funds. No Federal and few State agencies have accepted the responsibility for monitoring the management and use of patient funds. MSA has sent a letter to all State Medicaid agencies urging them to increase their activities in the protection of patients funds. MSA is investigating alternative methods of enforcement that will insure the protection of the patients and their interests.

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